

PRIMARY HEALTH CARE AND PLANNING  
IN CUBA AND COSTA RICA

A Thesis

Presented to the Faculty of the Graduate School  
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in Partial Fulfillment of the Requirements for the Degree of  
Doctor of Philosophy

by  
Priscilla Rivas

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PRIMARY HEALTH CARE AND PLANNING  
IN CUBA AND COSTA RICA

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Cornell University 1988

This dissertation compares the efforts of Cuba and Costa Rica to provide primary health care (PHC) through the integration of health and development planning, regionalization of health services, and community participation. The study reports the delivery of PHC and the health planning processes through which PHC has been organized. The central questions examined are: (1) whether Cuba and Costa Rica have delivered PHC to the extent they claim? (2) what role, if any, the integration of economic and health planning, regionalization of health services, and community participation have played in the delivery of PHC? and (3) whether the delivery of PHC is dependent on health planning and, if so, what type? The purpose has been to establish the relationship between health planning and the delivery of PHC in the two Latin American countries with best health indices. Both have successfully implemented PHC, but their socioeconomic structures are different: Cuba is a socialist centrally planned economy and Costa Rica is a capitalist, market economy.

The fulfillment of descriptive criteria for PHC in Cuba and Costa Rica was used to examine the central questions from a historical and institutional perspective. The data were gathered through interviews with planning officials and with the PHC unit staffs of each country. Six months were spent in Cuba, and twelve months in Costa Rica, between 1983 and 1985.

More similarities than differences in the delivery of PHC and the health planning process in both settings were found. Despite the lack of formal integration of economic and health planning, the problems in establishing regionalization as a process, and limited community participation, Cuba and Costa Rica have been able to successfully deliver PHC and improve health status. Many health and non-health related activities were responsible for the achievements in health status and PHC in both countries. The main conclusion is that health improvement and the effective implementation of PHC can be achieved in different settings using multiple approaches if those with political power are willing to invest resources in the health sector and in the economic and social sectors relevant to health status improvement.

## BIOGRAPHICAL SKETCH

Priscilla Rivas was born in Manhattan, New York on February 5, 1953 and attended private elementary schools in San Juan, Puerto Rico. Later she attended the University of Puerto Rico High School. Rivas received a Bachelor of Science degree in Nutrition and Dietetics from the University of Puerto Rico in 1975. Subsequently she completed a one-year Clinical Dietetics Internship in the San Juan Veterans Administration Hospital. As a Registered Clinical Dietitian affiliated to the American Dietetic Association she worked for two years in Veterans Administration Hospitals in Illinois. At the time, she also worked as a volunteer with Mexican migrant workers. The latter experience brought about the sudden awareness that the poor lacked adequate health services in the wealthiest nation of the world. This started a period of intense questioning about the reasons behind the unequal access inherent in the traditional delivery of health services in the United States and Latin America. A rigorous course of study that could lead to the answers pursued and possible solutions led the author to enter the International Nutrition Department at Cornell University. However, one year later a greater interest had developed in health and development planning issues in the Third World. As a result, the author entered the City & Regional Department (C&RP) at Cornell University to complete a doctorate in that field.

The authors' interest in comparative studies in health and development led to the dissertation research topic, namely health planning and primary health care in Cuba and Costa Rica. In 1981, Rivas traveled to Cuba to do preliminary research for a period of two weeks. Preliminary research was also undertaken in Costa Rica in mid-1983 funded by a Scott Paper Company research grant. After extensive talks with Cuban officials in the Cuban Interests Section in Washington, D.C. the Cuban government granted her permission to do research in Cuba for a period of six months in 1983. The author was funded by a Cornell University Latin American Studies Grant. In 1984, she won a Fulbright Research Grant to undertake doctoral dissertation research in Costa Rica for twelve months.

In 1987 the author worked in Nicaragua as a short-term nutrition planning consultant for the Pan American Health Organization. Currently she holds a post-doctoral research position in the Center for International and Comparative Studies at the University of Iowa.



To the people of Cuba and Costa Rica  
May their achievements promote  
health and peace  
in the troubled Central American region

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## LIST OF ABBREVIATIONS

CCSS	:	Social Insurance Fund (Costa Rica)
CMEA	:	Council for Mutual Economic Assistance
CMM	:	Community Medicine Model (Cuba)
ECLA	:	Economic Commission for Latin America
EMPS	:	Economic Management and Planning System (Costa Rica)
ICAS	:	Institutions of the Central Administration of the State (Cuba)
JUCEPLAN	:	Planning Ministry (Cuba)
MIDEPLAN	:	Planning Ministry (after 1979, Costa Rica)
MINSAP	:	Health Ministry (Cuba)
NAPP	:	National Assembly of Peoples Power (Cuba)
OFIPLAN	:	Planning Ministry (before 1979, Costa Rica)
PAHO	:	Pan American Health Organization
PHC	:	Primary Health Care
PLN	:	National Liberation Party (Costa Rica)
WHO	:	World Health Organization

## CHAPTER I

### THE IDEA OF PRIMARY HEALTH CARE

This dissertation compares the efforts of Cuba and Costa Rica to provide primary health care (PHC) through the integration of health and development planning, regionalization of health services, and community participation. The study reports the delivery of PHC and the health planning processes through which PHC has been organized. Cuba and Costa Rica have the two highest levels of health in Latin America,<sup>1</sup> and both have implemented a PHC strategy. Both have used a multisectorial approach to health and development planning, have regionalized health services, and have promoted community participation in PHC.<sup>2</sup> Each country, however, is based on a different socioeconomic system: Cuba on a socialist economy and Costa Rica on a mixed, but essentially capitalist economy. Remarkable

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<sup>1</sup>. This is based on a World Health Organization (WHO) review of the two countries' health systems and achievements; see WHO, Sixth Report on the World Health Situation: Part II, Review by Country and Area (Geneva: WHO, 1980).

<sup>2</sup>. The UNICEF/WHO Joint Committee on Health Policy selected Costa Rica for a comparative study because of its progress in PHC; see UNICEF/WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care (Geneva: WHO, 1981). The Cuban Ministry of Health and the WHO sponsored an International Conference titled "Health for All: 25 Years of Cuban Experience" based on Cuba's achievements in PHC, see Halfdan Mahler, "Address, Inaugural Session International Conference Health for All: 25 Years of Cuban Experience" in MINSAP/WHO, International Conference, Health for All: 25 Years of Cuban Experience, July 3-9, 1983, La Habana, Cuba.

health improvements have been achieved in both countries and PHC has been implemented with success using similar health planning methodologies in both settings. Is this outcome a consequence of the health planning process, or is it to be explained by a historical tradition of social concern, or by some other factor(s)? Since no documentation of the health planning process in Cuba and Costa Rica previously existed, this study will help discern its influence on the success of PHC in both countries.<sup>3</sup> An historical overview of the socioeconomic and health systems in both settings will also display the evolution of factors that promoted concern for social welfare and political commitment to PHC.<sup>4</sup>

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<sup>3</sup>. Albert F. Wessen argues that few good comparative health studies have been done. Among the reasons stated are a lack of descriptive data among countries lack of a strong theoretical basis, and authors political biases in comparisons of health systems with governments having different ideological commitments. This dissertation hopes to fill this gap. For more information see Albert F. Wessen, "Editorial: Comparative Studies of Health Systems: What Is Needed Now?" Comparative Health Systems Newsletter 9, no. 1 (1987): 1-2.

<sup>4</sup>. According to the WHO, political commitment to PHC will depend on one authority being responsible for it on behalf of the government. Thus, the first reform to be considered in many countries will be to strengthen the status of the ministry of health or analogous authority on national health work. In addition, ministries of health, on behalf of the government, will make efforts to ensure the support of public figures, political parties, religious and civic leaders, trade unions, and influential nongovernmental organizations. See, WHO, Global Strategy for Health for All by the Year 2000 (Geneva: WHO, 1981), pp. 55-57.

Traditional delivery of health services usually benefits only certain groups of the population.<sup>5</sup> Governments allocate most health resources for sickness-related problems, not to promote conditions leading to health. The response from health researchers and providers has been to search for a new strategy for health development, and this new strategy constitutes the basis of the PHC approach sponsored by the World Health Organization (WHO) and the United Nations Children and Education Fund (UNICEF).<sup>6</sup> The basis of the PHC strategy is not merely to improve health services, but to comprehend and attack the range of social, political, and economic factors that tend to impair health.

In the WHO model an ideal PHC delivery system does not exist. Each country must create its own organization. Yet, certain features are mandatory.<sup>7</sup> First, there must be easy access and long hours of availability so patients will not be compelled to use the emergency room of the local hospital or private medical services. Second, continuity of care requires coordination with higher levels of care. Third,

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5. John Bryant, Health and the Developing World (Ithaca, N.Y.: Cornell University Press, 1969), pp. ix-xvi.

6. Whenever the term "PHC strategy" is used it will refer to the WHO sponsored PHC strategy.

7. WJ. Stephen and Barbara Starfield are the only two authors who deal with the question of the essential features of PHC delivery; see WJ. Stephen, "Primary Medical Care and the Future of the Medical Profession" World Health Forum 2, no. 3 (1980): 315-24, and Barbara Starfield, "Measuring the Attainment of Primary Health Care," Journal of Medical Education 54 (1979): 361-69.

more comprehensive services will encourage patients to use PHC and not go directly to the secondary and tertiary levels. Fourth, the more the PHC facility can identify its eligible population, and vice versa, the more individuals in the community will seek care from that unit.

Promoting PHC is a difficult task regardless of socio-economic system. For example, the status of the PHC physician is low, compared to that of specialists in large urban areas of most industrialized countries. This is true both in countries with free-market economies and in Eastern Europe and the USSR, where there is at least a theoretical emphasis on PHC.<sup>8</sup> The positive achievements of both Costa Rica and Cuba in PHC implementation suggest the need to understand the dynamics of their health planning processes and the influence of these processes on PHC delivery.

### Two Kinds of Health Planning for PHC

The inefficacy of health planning with few or no links to development planning has been documented in various

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<sup>8</sup>. WJ. Stephen, "Primary Medical Care and the Future of the Medical Profession," p. 316.

contexts.<sup>9</sup> The awareness that health development is a result of social, political, and economic conditions, and not merely an outcome of technology, has resulted in an increasing insistence by the WHO on having health policies and strategies fully integrated into national development plans.<sup>10</sup> With the growing gap between health needs and resources in poor countries, planning for PHC has come again to be regarded as the most important means whereby the health sector can effectively contribute to overall socio-

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9. For example, in nutrition planning see NS. Scrimshaw et al., "Nutrition and Infection Field Study in Guatemalan Villages, 1959-1964" Archives of Environmental Health (1969): 51-62; and Alan Berg, The Nutrition Factor: Its Role in National Development (Washington, D.C.: Brookings Institution, 1973). On health care facilities construction programs see JR. Lave and LB. Lave, The Hospital Construction Act: An Evaluation of the Hill-Burton Program, 1948-1973 (Washington, D.C.: American Institute for Public Policy Research). More generally, see Ray Elling, Cross-National Study of Health Systems: Political Economies and Health Care (New Brunswick: Transaction Books, 1980); and UNICEF-WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care.

10. The multisectoral nature of health development had been recognized previously. For extensive examples, see Ray Elling, Cross-National Study of Health Systems: Concepts, Methods, and Data Sources (Detroit: Gale Research Company, 1980). Nonetheless, the WHO finally acknowledged the concept and declared "Health for All by the Year 2,000" as its official target for all WHO member states in 1978 promulgating PHC as the basis for the "Health for All" strategy. See WHO, Primary Health Care: Report of the International Conference on Primary Health Care. Alma-Ata. USSR, 6-12 September 1978 (Geneva: WHO, 1978).



economic development.<sup>11</sup> Currently, however, there is a debate among promoters of the PHC strategy. Some believe that PHC is an alternative for health care delivery; others consider it a strategy for health development. The former support "selective PHC,"<sup>12</sup> a strategy that encourages specific, cost-effective technologies and programs for disease reduction which might or might not be linked to a national health system. The latter emphasize the WHO-PHC strategy labeled as "comprehensive PHC," which focuses on process and change for health development through a national health system rather than on the isolated elaboration of programs designed for repetition and replication.<sup>13</sup>

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11. The concept that PHC is "poor medicine for the poor" using primitive "appropriate technology" and uneducated local "health workers" and "traditional healers" or "barefoot doctors," has been criticized as the wrong model for PHC; see DD. Venediktov, "Lessons from Alma-Ata," World Health Forum 2, no.3, (1981): 332-40; DB. Lewis, "The Impact of Health and Education in a Developing Country: A Macro-Economic Simulation." (Ph.D. dissertation, Cornell University, 1973).

12. For more information on selective PHC see JA. Walsh and KS. Warren, "Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries," Social Science and Medicine 14C (1980): 145-64; O. Gish, "Selective Primary Health Care: Old Wine in New Bottles," Social Science and Medicine 16 (1982): 1049-63; and Peter A. Berman, "Selective Primary Health Care: Is Efficient Sufficient?" Social Science and Medicine 16 (1982): 1054-59.

13. For an excellent analysis of the debate between WHO's strategy for PHC and selective PHC see Susan B. Rifkin and Gill Walt, "Why Health Improves: Defining the Issues Concerning 'Comprehensive Primary Health Care' and 'Selective Primary Health Care'," Social Science and Medicine 23, no. 6 (1986): 560.

The one-sided idea that PHC can be promoted only within a national health system or through health programming does not take into consideration social, political, economic, and cultural differences among countries. Evidence collected in this study from Costa Rica and Cuba shows that despite the difficulties and shortcomings, PHC can be effectively implemented in different settings using multiple approaches. Surprisingly, the significance of multiple strategies to achieve the same goal has been ignored in most PHC studies. The WHO-PHC strategy is comprehensive, but it is highly idealistic and extremely difficult to implement unless deep socioeconomic transformations take place. Obviously, an international organization cannot implement such changes. Conversely, planners who promote "selective PHC" focus interventions on specific groups through particular medical technologies and divert resources from the development process to implementation of programs. As a result, it is unlikely that "selective PHC" can lead to sustained improvements in health.

In defending one strategy over the other, political ideology gets in the way. Our understanding of health and health policy, as in any area of socioeconomic reality, is influenced by ideological interpretations of the social order. Thus the goal of achieving health for all by the year 2000 is sometimes viewed as an easy task facing few structural obstacles if a free-market or mixed-economy

development strategy is followed.<sup>14</sup> Conversely, those who defend socialism contend that the obstacles to implementation of PHC are insurmountable in a market economy and that it can take place only in socialist countries.<sup>15</sup>

In remarkable contrast to these two strongly held and conflicting assertions, my findings are that in both socialist Cuba and capitalist Costa Rica the PHC systems have strikingly similar achievements and problems. For example, efficient integration of the economic and health planning process would be expected in Cuba and, marginally, in Costa Rica, but this proved not to be. There is a presupposition of rationally planned, not improvised, regionalization schemes for economic and health planning. Yet in both cases improvisation and deficiencies in the health planning process for regionalization were found. Most important, the constraints on and accomplishments of each PHC system were

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14. Those who promote selective PHC usually hold this simplified view of the process for its implementation. For more information see Emanuel De Kadt, "Ideology, Social Policy, Health, and Health Services: A Field of Complex Interactions," Social Science and Medicine Vol. 16 (1982): 742-43.

15. For example, Catherine McDonald in her idealized view of socialist systems argues that only centralized or concerted countries refuse to allow the battles of health professionals over dividing the medical sector to interfere with the delivery of health services. See Catherine A. McDonald, "Political-Economic Structures--Approaches to Traditional and Modern Medical Systems," Social Science and Medicine 15A (1981): 106. Lori Ann Thrupp states that if truly effective changes in the health and pharmaceutical sectors are to be achieved socialism is a necessary precondition. See Lori Ann Thrupp, "Technology Policy and Planning in the Third World Pharmaceutical Sector: The Cuban and Caribbean Community Approaches," Social Science and Medicine 14 no.2 (1984): 211.

strikingly similar: (1) both have been unable to coordinate the primary level with other levels of care; (2) patients in both countries skip the primary level and go directly to the secondary or tertiary levels of care; (3) continuity of care is assured by medical records in both settings, but patient information is not transferred between levels of care; (4) continuity of care by health workers in both is very aggressively sought in an effort to provide follow-up care whether the patient is ill or not; and (5) both countries have improved health indices dramatically because mortality and morbidity were often caused by communicable diseases which have been virtually eradicated. It is clear that multiple strategies for good health are available and there seems no clear connection to socioeconomic structure. In addition, specific health planning methodologies appear not to be the prerogative of particular socioeconomic systems. For example, comprehensive health planning may not exist in socialist economies and programmatic health planning may not be limited to market economies. Moreover, the assumption that health and economic planning must be integrated in a socialist context proved to be untrue.

### The Plan and Themes of this Study

Instead of debating the superiority of one PHC strategy over another, this study will show that in Costa Rica and Cuba both selective and comprehensive strategies are used with mixed results. Yet distinguishing between these two

strategies may help us to understand what aspects of the planning process hinder or promote the development of a health system based on PHC. This dissertation compares Cuba's and Costa Rica's efforts to promote deliver PHC through the integration of health and development planning, regionalization, and community participation.

As a preface to the discussion of the delivery of PHC and the health planning process in Cuba and Costa Rica, an overview of the historical development of the socioeconomic and health structures in both countries is presented in Chapter II.

Much of the health planning literature that evaluates PHC is limited to loosely defined descriptions of criteria required for the implementation of PHC. The first section of Chapter III discusses the problem of evaluating PHC and specific criteria that can be used to examine strategies and guidelines that could aid the design of national health systems based on PHC. The second section of Chapter III describes the method of inquiry used in this study and provides a short account of the fieldwork.

Chapters IV through VI constitute the empirical portion of the dissertation. The following questions are used as the general framework for analysis throughout these chapters: (1) Do Cuba and Costa Rica really deliver PHC to the extent they claim? (2) What role, if any, has the level of integration between economic and health planning, regionalization of health services, and community participation played in the delivery of PHC? (3) Does the delivery

of PHC depend on health planning? If so, what kind? (4) What are the constraints to health planning in small underdeveloped socialist and market countries? (5) How much integration is there between economic and health planning in each country? Chapters IV and V look into the first and second questions, and, based on descriptive criteria for PHC, try to establish the extent to which PHC exists in each country. Using questions three through five as a guiding framework, Chapter VI then examines the health-planning process in each country and determines if the delivery of PHC is dependent on health planning and, if so, on what kind of health planning.

Based on the analysis included in Chapters IV through VI, Chapter VII discusses the implications of these results for health planning and for planning for PHC more broadly. Finally, Chapter VIII summarizes the findings and draws the conclusions.

### Method of Inquiry

The research strategy used in this dissertation was primarily intended to assess the fulfillment of the descriptive criteria for PHC delivery in Cuba and Costa Rica. This assessment provided the basis for the subsequent analysis of the interaction between the delivery of PHC and the economic and health planning processes, regionalization of health services, and community participation of these two countries

as reported in Chapter VI. This analysis was done from a historical/institutional perspective.

Preliminary research work was undertaken in the Pan American Health Organization (PAHO) headquarters in Washington, D.C. during April 1983 where the author interviewed PAHO officials regarding the PHC strategy promoted by the WHO.

Fieldwork was undertaken in Cuba during six months between July and December 1983 and in Costa Rica for twelve months between October 1984 and October 1985. The two most important entities reached to help arrange key contacts for the fieldwork were the Cuban Interests Section in Washington, D.C., before the authors's fieldwork in Cuba, and the United States Information Agency in the U.S. Embassy in San Jose, Costa Rica, after arriving in Costa Rica.

Objective and subjective data were collected in the two countries by three methods: (1) observations made during visits to primary health care facilities; (2) interviews to health planners, health care providers, and economic planners; and, (3) library and public documents research. A total of twenty-six interviews were completed in Cuba and twenty-one in Costa Rica. The following institutions arranged for visits and interviews: (1) Ministry of Public Health, Havana, Cuba; (2) Ministry of Planning, Havana, Cuba; (3) Center for Demographic Studies, Havana, Cuba; (4) School of Economics and Planning, University of Havana, Cuba. (5) Ministry of Planning, San Jose, Costa Rica; (6) Ministry of Public Health, San Jose, Costa Rica; (7) Office

of Family Appropriations, San Jose, Costa Rica; and the (8) United States Embassy, San Jose, Costa Rica. Interviews and visits to health care facilities were requested, and granted without exception in Costa Rica. In Cuba visits to the Ministry of Planning and to the Health Planning Office within the Ministry of Health were denied. The justification given by Cuban health officials was that these two entities were extremely sensitive government institutions and were not open to foreign scrutiny. In both cases, interviews with Cuban economic and health planners were arranged at some other location, but not within the Ministry of Planning (JUCEPLAN) or the Health Planning Office.

The framework for the interviews and observations was established through the use of three questionnaires, each one dealing with: (1) the delivery of PHC, (2) the health planning process, and (3) the economic planning process. The questionnaires used are duplicated in Appendix A. All interviews were tape-recorded after requesting permission from the respondent. In most cases, a copy of the questionnaire was given to the interviewee. The researcher and respondent then went through the document concurrently, with the former clarifying questions when and if necessary. This method promoted a less rigid setting and avoided having to read out questions. When the interviewee was a highranking official, such as the minister of health or minister of planning, more formal interviews were conducted with questions enunciated by the researcher.



In this way subjective and objective data from the following four areas were collected. The key questions included in each of these areas are presented.

1) Historical Development of the Socioeconomic Structures of Cuba and Costa Rica. To determine the effect of particular economic policies on the delivery of health services, including when and how planning was introduced into the development process.

2) Historical Development of the Health System of Cuba and Costa Rica. What was the health situation in both countries before health standards were improved? How has the allocation of financial and human resources changed overtime? What has been the distribution of financial and human resources between regions?

3) Delivery of PHC. Can PHC facilities arrange for the patient to receive all necessary health care services? Can the PHC facility identify the eligible population? Does the system provide easy access, both geographically and by having long hours of availability? Does the system require some form of continuity, either by the practitioner or by medical records, or both?

4) Planning Process. Has the development strategy emphasized growth with a reduction of social inequalities? What emphasis has been given to urban versus rural development? Do health and development planners operate with a clearly defined framework and methodology or is planning done on the basis of ad-hoc intuition? What are the mechanisms by which budgeting and implementation of

decisions about resource allocation achieved? How is the community involved in the planning process?

### Shortcomings

The many drawbacks of gathering data through personal interviews and observations are well documented and should be remembered when assessing the findings. Moreover, the researcher's experience with the interviewees in each country was different. For example, in Cuba high-ranking officials were usually older and had worked for the Cuban government since the Revolution. As a result, they tended to be more secure, open, and willing to discuss the problems they were experiencing. Conversely, middle-rank officials were younger and very careful in their responses to avoid controversy. They usually limited their answers to how the health or economic system was supposed to work, not to how it was actually working. In Costa Rica, health and planning officials were very open about how the health and economic planning system was actually working and its multiple constraints independent of their rank and whether or not they belonged to the political party in power.

## CHAPTER II

### HISTORICAL DEVELOPMENT OF THE SOCIOECONOMIC AND HEALTH STRUCTURE IN CUBA AND COSTA RICA

To analyze the development of health-planning systems and PHC in Cuba and Costa Rica, the historical context in which they evolved must be understood. This background will help elucidate the evolution of factors that promoted concern for social welfare and political commitment to PHC. To provide such a perspective for each country, this chapter is divided into three sections. The first section provides a historical overview of the socioeconomic and health structure in Cuba and Costa Rica since the colonial period; the second section offers a more detailed analysis of the evolution of economic and health-planning concepts and strategies in both countries since the 1960s; and the third section reveals the improvement in health care delivery, health status, and public health expenditures through time. This chapter will show that, historically, concern for social welfare has been evident in both countries and has been crucial in their efforts to improve health status. It will also illustrate that the multiple economic policies and planning strategies used since the 1960s and the outcome of such policies have not been a decisive influence on their commitment to health improvement.

## CUBA

Cuba's steady and sustained achievements in the health field since the revolution in 1959 are reflected in its excellent health standards. Life expectancy at birth for both sexes increased from 61.8 years in 1960 to 73.5 years in 1982. Costa Rica and Cuba have the highest life expectancy in Latin America. Infant mortality decreased from 38.3 per thousand live births in 1968 to 17.3 in 1982, the lowest in Latin America.<sup>1</sup> Few developing countries have achieved these life expectancy and infant mortality rates, which are superior to those of the less advanced European countries.<sup>2</sup>

Cuba, however, enjoyed relatively high health standards before the Revolution and experienced solid progress during the 1950s. By 1960, before new policies had been implemented by the government, life expectancy had risen to 64 years.<sup>3</sup> Moreover, when Cuban general and infant mortality rates for 1958 are compared with health

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1. Republica de Cuba, Ministerio de Salud Publica, Informe Anual 1982 (La Habana, Cuba: Ministerio de Salud Publica, 1982), pp. 18 and 25.

2. Sergio Diaz-Briquets and Lisandro Perez, "Cuba: The Demography of the Revolution," Population Bulletin 36, no. 1 (April 1981): 9.

3. Nick Eberstadt, "Literacy and Health: The Cuban Model," Wall Street Journal, December 10, 1984; Diaz-Briquets and Perez, "Cuba," p. 3.

indices for the rest of Latin America, Cuba's are the lowest.<sup>4</sup> Although the gains in health since the revolution are noteworthy, they are not as dramatic as Cuban health officials proclaim them to be or as they appear in the health literature if compared to the health profile before the revolution. The next section will analyze the historical evolution of the socioeconomic and health systems that influenced the strides in health that occurred before the Cuban Revolution in 1959.

### Historical Evolution

Very slow economic development characterized the first two centuries of Spanish occupation. Cuba's main role, because of its large and secure harbors, was to provide supplies to merchant fleets and military personnel from or on their way back to Spain.<sup>5</sup>

Between 1823 and 1860, a sugar-based economy emerged. Wars of independence and instability marked the period between 1868 and 1898. The last war of independence and the collapse of slavery in the 1880s promoted the

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4. Carmelo Mesa-Lago, The Economy of Socialist Cuba: A Two-Decade Appraisal (Albuquerque: University of New Mexico Press, 1981), p. 166. Vicente Navarro, however, contends that the social and economic conditions of the mass of the Cuban people before the Revolution were comparable to most of those in Latin America. See Navarro, "Workers and Community Participation and Democratic Control in Cuba," International Journal of Health Services 10 no. 2, (1980): 197-215.

5. Ross Danielson, Cuban Medicine (New Brunswick, N.J.: Transaction Books, 1979), p. 34.

emergence of sugar corporations, half of them owned by U.S. firms.<sup>6</sup> The nineteenth century was a period of rapid economic expansion and of high mortality from epidemics of infectious diseases. The most prevalent illnesses were yellow fever, malaria, hookworm, and tuberculosis.

In 1898, at the close of the Spanish-American War, the United States Army occupied the island. This occupation had a profound effect on health, leading almost immediately to a decline in the mortality rate through the eradication of certain epidemic diseases and decreased incidence of others.<sup>7</sup> In 1899, President William McKinley named Major General Leonard Wood as military governor of Cuba. Wood had received a degree in medicine from Harvard University in 1884 and was interested in alleviating Cuba's health problems.<sup>8</sup> Extensive sanitary reforms were undertaken. Although most effective in the capital city of Havana, these reforms improved the health standards of the entire country. Among the measures instituted were burial regulations, reorganization of the health statistics service, inspection and regulation of establishments where food was prepared, and renewed attention to drainage, sewage, and street paving in the cities.<sup>9</sup> The most

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<sup>6</sup>. Ibid., pp. 73-74.

<sup>7</sup>. Sergio Diaz-Briquets, The Health Revolution in Cuba (Austin: University of Texas Press, 1983), p. 13.

<sup>8</sup>. Russell H. Fitzgibbon, Cuba and the United States. 1900-1935 (New York: Russell & Russell, 1964), pp. 30, 32.

<sup>9</sup>. Diaz-Briquets, The Health Revolution in Cuba, p. 32.

important achievement of the period of military occupation was the program to eradicate yellow fever.<sup>10</sup> The overall result of these interventions was the decrease of the mortality rate per 100,000 for infectious diseases in Havana from 1,400 in 1898, to 118 in 1902.<sup>11</sup> Table 2.1 shows the results of the measures taken by the U.S. military forces. The health achievements between 1898 and 1901 were the result of increased expenditures and decisions taken by the U.S. government. During this two to three year period more than 20 million pesos, or over 36 percent of government expenditures, were spent for sanitation. Conversely, during the Spanish occupation no more than 200 thousand pesos per year were normally allocated for sanitary purposes.<sup>12</sup>

Cuba gained formal political independence from the United States in 1902. The Platt Amendment was incorporated into the Cuban constitution, however, granting the U.S. government the right to intervene in Cuban affairs under certain conditions. Of relevance to public health was the following section of the amendment:

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10. The Yellow Fever Commission, appointed by Governor Wood, followed the theories of a Cuban physician of British descent, Dr. Carlos J. Finlay and conclusively proved that mosquitoes were the main vehicle by which yellow fever is transmitted to man. A vigorous campaign was undertaken to destroy the breeding grounds of mosquitoes. See Fitzgibbon, Cuba and the United States. pp. 37-40.

11. Diaz-Briquets, Health Revolution in Cuba, p. 33.

12. Ibid., p. 201.

Table 2.1

Death Rates for Certain Infectious Diseases,  
City of Havana, 1890-1902  
(Per 100,000 Inhabitants)

Year	Yellow Fever	Smallpox	Malaria	Diphtheria	Infantile Tetanus	Typhoid Fever	Tubercu- losis
1890	146.1	5.7	80.6	49.8	168.4	86.8	761.7
1891	166.1	70.4	94.7	36.4	149.3	71.8	729.3
1892	163.9	0	92.8	38.6	117.5	168.0	701.6
1893	224.2	3.6	108.5	66.4	127.4	94.0	606.6
1894	170.0	96.1	89.4	33.8	77.0	44.5	584.7
1895	242.3	79.3	90.3	11.0	78.9	80.2	711.3
1896	553.4	433.4	194.2	8.2	100.2	210.2	681.2
1897	364.9	597.1	344.9	15.3	91.4	288.8	819.2
1898	57.0	70.4	799.3	9.6	72.5	423.3	1171.1
1899	42.6	1.6	375.5	16.1	38.0	57.8	405.3
1900	124.5	0.8	138.2	6.0	55.8	36.2	341.8
1901	7.0	0	59.0	9.8	50.0	32.4	351.8
1902	0	0	29.3	9.5	25.9	33.1	361.2

Source:

Sergio Diaz-Briquets, The Health Revolution in Cuba  
(Austin: University of Texas Press, 1983), pp.  
30-31.



That the government of Cuba will execute, and, as far as necessary, extend the plans already devised or other plans to be mutually agreed upon, for the sanitation of the cities of the island, to the end that a recurrence of epidemic and infectious diseases may be prevented, thereby assuring protection to the people and commerce of Cuba, as well as to the commerce of the southern ports of the United States and the people residing therein.<sup>13</sup>

The future development of public health in Cuba was profoundly influenced by this provision because it forced the Cuban government to maintain close surveillance over the country's sanitary conditions. Nevertheless, the system of public health administration inherited from General Wood failed. The public health system was strongly decentralized into municipal finance and control, and although a brilliant sanitation code had been drafted, the responsibility for its promotion rested with local boards. Cesar Rodriguez Exposito contends:

The Sanitary Organization that was established with the Republic was in theory perfect, but in practice it resulted in great difficulties, since the Local Boards remained inactive for lack of economic resources. The outpatient, staff, and hygienic services ceased to be offered. In Havana this did not occur, for the State continued to finance sanitation.<sup>14</sup>

As a result, the second time the United States administered Cuba, from 1906 to 1909, under Governor Charles E. Magoon, the first nationwide ministry of health in the world

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<sup>13</sup>. The distance between Cuba and the United States is less than ninety miles. See Fitzgibbon, Cuba and the United States, p. 273.

<sup>14</sup>. Cesar Rodriguez Exposito, "La Primera Secretaria de Sanidad del Mundo se Crea en Cuba," Cuadernos de Historia de Salud Publica 25 (1964): 16.

was established to centralize the health system.<sup>15</sup> Sanitation and charities were joined under a single cabinet-level ministry, and local health posts were to be centrally appointed. Through this ministry, the central government funded a public health entity in each of the country's municipalities.<sup>16</sup> Yellow fever and infectious diseases received special attention. At the close of the first intervention U.S. officers engaged in sanitation activities were withdrawn. Later the Cuban congress did not assign sufficient funds to continue the sanitation efforts already under way. As a result, the fight against infectious diseases was as thorough and covered a wider area than that conducted during the first intervention.<sup>17</sup> During the first half of the twentieth century, the Cuban economy was totally dependent on international trade in its agricultural commodities, particularly sugar, which constituted 70 to 90 percent of total exports. This dependency had both positive and negative effects on the economy. During the first two decades of the century, the sugar trade resulted in a high

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15. In 1906, as the result of an insurrection in Cuba, U.S. President Theodore Roosevelt, citing his responsibilities to Cuba under the Platt Amendment, intervened to end the war and assumed direct control of the Cuban government until 1909. Charles E. Magoon was commissioned to be the governor of Cuba. He had been a member of the Panama Canal Commission, governor of the Canal Zone, and minister to Panama. See, AR. Millett, The Politics of Intervention, The Military Occupation of Cuba, 1906-1909 (Ohio: Ohio State University Press, 1968), pp. 89-119.

16. Ibid.

17. David A. Lockmiller, Magoon in Cuba: A History of the Second Intervention, 1906-1909 (New York: Greenwood Press, Publishers, 1972), pp. 112-113.

rate of economic growth, which promoted the expansion of the health system through the 1920s and 1930s. Government-supported public health programs increased after 1933 and 1945, but the structure of control by the Ministry of Health was unaltered.<sup>18</sup> Problems related to overcentralization, urban/rural disparity, and inadequately trained physicians characterized the public health system. The following excerpt from the report by the U.S. Commission on Cuban Affairs in 1935 illustrates these problems:

The health organization is highly centralized. The central bureaus of the national health service have a large staff and a wide variety of activities. This centrally located technical staff limits its activities, in great part to the city of Havana, and seldom penetrates to the interior. The local health service of the city of Havana is highly organized and carries out a great deal of effective work...A large sum of money is allocated by the national government for the public health work in the interior, but most of this fund is expended for functions that properly belong to the Department of Public Works (cleaning of streets and garbage removal in the interior cities) ... The administrative work of the health department is carried out by physicians largely untrained in the technique of public health procedure, who devote only half their time to health work and who are paid a very modest salary ... Local communities, cities, towns, and municipios assume no direct responsibility for their own health protection, but look to the national government for every detail.<sup>19</sup>

Although the Platt Amendment was abolished in the 1930s, U.S. influence on Cuban matters continued to be intense until the socialist revolution. Sustained

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<sup>18</sup>. Ross Danielson, Cuban Medicine, op.cit., p. 119.

<sup>19</sup>. Report of the Commission on Cuban Affairs, Problems of the New Cuba (Washington, D.C.: Foreign Policy Association, 1935), p. 116.

economic growth was unattainable because the country was vulnerable to fluctuations in foreign trade. In addition, the reliance on sugar prevented economic diversification. Even though Cuba was an agricultural country, it depended on imports for its food supply. Income distribution was unequal and there was no subsistence agriculture sector.<sup>20</sup>

A 1951 World Bank study noted:

The general impression of members of the Mission, from observations in travels all over Cuba, is that living levels of the farmers, agricultural laborers, industrial workers, storekeepers, and others are higher all along the line than for corresponding groups in other tropical countries and in nearly all other Latin American countries. This does not mean that there is no dire poverty in Cuba, but simply that in comparative terms Cubans are better off, on the average, than the people of these other areas.<sup>21</sup>

By the late 1950s, 57 percent of the population lived in urban areas. Housing conditions in the rural areas remained poor, but increasing urbanization improved those conditions for the total population. Water and sewer systems were poorly developed, but better facilities were available in the urban areas. Moreover, medical advances in the United States were rapidly implemented in the highly specialized medical centers in the capital city of Havana.<sup>22</sup>

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<sup>20</sup>. Ibid., p. 38.

<sup>21</sup>. International Bank for Reconstruction and Development (World Bank), Report on Cuba (Baltimore: Johns Hopkins University Press, 1951), pp. 39-40.

<sup>22</sup>. Diaz-Briquets, The Health Revolution in Cuba, pp. 44-45.

The Mutualist Health Association (MHA) was established in the late nineteenth century to provide medical care to poor Spanish immigrants, but it eventually covered other sectors of the population, particularly the middle class. The principles under which an MHA operated were similar to those presently used by Health Maintenance Organizations (HMOs) in the United States. MHAs became the most common form of health care delivery during the first half of the twentieth century for those who could afford to become members. To join an MHA one paid a fee that entitled one to medical services and use of hospital facilities at no extra cost. According to Ross Danielson:

in 1933 under the weight of severe economic depression, about one-third of Havana's population had been covered in some way by mutualism, a fraction which was now approaching one-half in 1958, with some 350,000 in other cities. In 1952, mutualism absorbed almost forty percent of all direct consumer expenditures for health care; mutualism appeared to be the principal arena of institutional development in health care. But mutualism, by its urban concentration and its ability to include many marginal physicians and marginal institutions, continued to have an effect that was important throughout the period: mutualism served as an urban magnet to marginal physicians who might otherwise have followed equally marginal careers in rural communities. The subscribers of mutualism, the better employed and commercial middle classes, were thereby protected from the expense of private care (fee-for-service), on the one hand, and the inadequacy of public facilities, which were nominally free, on the other.<sup>23</sup>

One indicator of the population's access to health care is the number of physicians in proportion to the population. Physicians were highly concentrated in Havana

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<sup>23</sup>. Danielson, Cuban Medicine, p. 121.

and to a lesser extent in the provincial capitals. The shortage of physicians in the rural areas was severe. The better qualified physicians and the highly specialized hospital centers were located in the Havana area.<sup>24</sup>

Before 1959, Cuba was a market economy with modest state intervention. Ownership of the means of production was mostly private. After 1933, the state began to play a significant role in the expansion of social services, development financing and the sugar industry. Despite many economic shortcomings, by 1958 Cuba ranked among the top three or four countries of Latin America in socio-economic development.<sup>25</sup>

#### Early Efforts in Economic and Health Planning

Between 1959 and 1960, the first two years of the Revolution, the Cuban leadership contended that it was aware of the need for national economic planning, but such planning was delayed. The government nationalized all

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<sup>24</sup>. Ibid., p. 110.

<sup>25</sup>. Presently, Cuban authorities claim that Cuba's literacy rate was 25 percent by 1958, on the eve of the Revolution. Yet by 1953, the date of the last prerevolutionary census, the literacy rate for those fifteen years of age or over was 76.4 percent. Carmelo Mesa-Lago contends that by 1959 the literacy rate might have been about 79 percent. If so, it would have been one of the highest literacy rates for a nonindustrial nation at the time. See, Carmelo Mesa-Lago, "Alternative Strategies to the Social Security Crisis: Socialist, Market, and Mixed Approaches," in Carmelo Mesa-Lago, ed. The Crisis of Social Security and Health Care: Latin American Experiences and Lessons (Pittsburgh: Center for Latin American Studies, University of Pittsburgh, 1985), p. 316.

factors of production, which caused progressive breakdown of market mechanisms and brought about economic disarray.<sup>26</sup> In addition, nationalization initiated an exodus of managers and technicians, resulting in a lack of trained personnel.<sup>27</sup>

No adequate statistical base for economic planning was available, so it was impossible to obtain a reliable economic evaluation of the level of economic development reached and a forecast of the level of development

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<sup>26</sup>. By structural deformation of the economy, the Cubans mean low level of development of the factors of production resulting from an economy based on the monoproduction of sugar. See Michael Gutelman, "Cuba's Lessons on Economic Policies," in Cuba in Revolution, ed. Rolando E. Bonachea and Nelson P. Valdes (New York: Doubleday Anchor Books, 1972), pp. 232-34. See also Carmelo Mesa-Lago, The Economy of Socialist Cuba: A Two-Decade Appraisal (Albuquerque: University of New Mexico Press, 1981), p. 10. William G. Demas, The Economics of Development in Small Countries with Special Reference to the Caribbean (Montreal: McGill University Press, 1965), pp. 8-10.

<sup>27</sup>. Mesa-Lago, The Economy of Socialist Cuba, p. 13. See also Jose Luis Rodriguez, "Politica Economica de la Revolucion Cubana (1959-1960)," Economia y Desarrollo 54 (July-October 1979): p. 132.

desired.<sup>28</sup> Finally, some economists overvalued Cuba's potentialities and undervalued its limitations, thereby simplifying the country's economic problems. For example, some economists thought development would be fairly easy because land reform had taken place, an industrialization program was under way, and foreign trade was being diversified to a great extent with socialist countries. This last element was supposed to facilitate long-term planning under conditions of mutual advantage with the socialist-block countries.<sup>29</sup>

Because of these constraints, economic planning was not feasible. It was possible only to have a flexible economic policy that would guarantee the continuity of the new socioeconomic transformations. In March 1960, the government created the Central Planning Ministry, JUCEPLAN, to coordinate government policies and to guide the

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<sup>28</sup>. Juan F. Noyola, Mexican economist, was chief of the Economic Commission for Latin America mission to Cuba in 1959. Regarding the reliability of Cuban statistics before the Revolution he stated: Even though, relatively speaking, Cuba is one of the most developed countries in Latin America, with an income relatively high, it was until January 1, 1959, one of the Latin American countries with worst statistics. Cuba had reliable statistics in some areas: in sugar, in tobacco, in coffee, that is, in the export products, and also in electricity. However, it never had an industrial census; for twelve years an agricultural census was not taken, and even the fiscal and foreign trade statistics were deficient." See Juan F. Noyola, La Economia Cubana en los Primeros Anos de la Revolucion (Mexico: Siglo XXI Editores, 1978), pp. 104-5. See also Michael Kalecki, "Un Esbozo Hipotetico del Plan Quinquenal 1961-1965 para la Economia Cubana," in Michael Kalecki, Ensayos Sobre las Economias en Vias de Desarrollo (Barcelona: Editorial Critica, 1980), p. 170.

<sup>29</sup>. Noyola, La Economia Cubana, p. 103. Kalecki, "Un Esbozo Hipotetico," pp. 172-73.



private sector through indicative planning. After Cuba's President, Fidel Castro, declared his commitment to socialism, these functions were never exercised. JUCEPLAN became the maximum authority in the area of economic policy and state central planning.<sup>30</sup> The political leaders instructed JUCEPLAN to devise annual and medium-range macro-development plans. Financing was increasingly controlled by the Ministry of Finance through the state budget.<sup>31</sup>

By 1961, the political leaders conceived a new economic development strategy; its main objective was to transform Cuba into an industrialized country by developing heavy industry, diversifying agriculture, and implementing import substitution. These objectives became part of the 1962-65 Economic Development Plan, but it was unworkable because of lack of data on the basic intersectoral economic relations and high dependence on foreign trade.<sup>32</sup> This medium-range plan was prepared with the aid of Polish and Soviet planners.<sup>33</sup> Another medium-range plan (1961-65) was drawn by a United Nations economist,

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<sup>30</sup>. Noyola, La Economia Cubana, p. 126. See also Mesa-Lago, Economy of Socialist Cuba, pp. 12-13.

<sup>31</sup>. Mesa-Lago, The Economy of Socialist Cuba, p. 15.

<sup>32</sup>. Jose L. Rodriguez, "La Economia de Cuba Socialista," Economia y Desarrollo 61 (1981): 134.

<sup>33</sup>. Mesa-Lago, Economy of Socialist Cuba, p. 16.

Michael Kalecki, but was rejected by the Cuban government.<sup>34</sup>

In 1962, an annual plan was prepared with the aid of Czech planners. This plan was also useless because of the lack of reliable statistics and trained personnel. In addition, the Czech model was not adapted to the sugar-based developing economy of Cuba. The annual plans drawn up for 1963 and 1964 were never enforced.

Economic planning did not develop at this stage for two other reasons. First, coordination was poor among government agencies and ministries, and there were no control procedures within the ministries. Second, political leaders were the true policy makers and did not consult JUCEPLAN regarding economic decisions, which resulted in great inconsistencies. Also, no investment plan existed, which resulted in poor capital productivity. Last, the economy was financed through budgetary allocations to state enterprises.<sup>35</sup>

As a result, during the 1960s and early 1970s, planning for the health sector concentrated on extension of coverage. Cuban health policymakers, who were also the political leaders, as well as Cuban health planners determined that extension of coverage was required to increase access to health services and to distribute

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<sup>34</sup>. Kalecki, Ensayos Sobre las Economias, p. 171.

<sup>35</sup>. Mesa-Lago, Economy of Socialist Cuba, p. 16.

resources equitably. But no real conceptual framework was established. Consequently, plans lacked direction and were organized as a conglomerate of programs independent from the system of plans for socioeconomic development.<sup>36</sup> In this setting, it was nearly impossible to interrelate health and economic planning. Moreover, the methodology used for health planning was designed by the Pan American Health Organization (PAHO) whose representatives in Cuba were attempting to design programs to help solve the main health problems.<sup>37</sup> Although health programming was adapted to Cuba's needs and characteristics, it was unrelated to the economic policies and economic planning efforts then being promoted.

By the end of the 1960s, changes in structure were made at the central level of the Ministry of Public Health (MINSAP). Two vice-ministries were created, for Medical Care and Teaching and for Hygiene and Epidemiology. Each had several advisory planning groups that acted as the top planning and evaluating authorities. Their main role was to develop the norms and procedures to be followed at the national, regional, and provincial levels. These advisory groups were staffed by the most prominent faculty of the medical schools and were regarded as the top authorities in each specialty. This structure was the same at the

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<sup>36</sup>. Arsenio Carmona Gutierrez and Mario Escalona Reguera, "El Desarrollo de la Higiene Social y la Organización de los Servicios de Salud en Cuba," Revista Cubana de Administración de la Salud 8 (July/September 1982): 308.

<sup>37</sup>. Ibid.

provincial and regional levels. The region was still part of the political-administrative structure and was the lowest level for planning.<sup>38</sup>

In 1966, the Ministry of Finance was abolished and all its functions taken over by the National Bank. The budgetary financing system was expanded to cover the entire economy, and the National Bank became an overseer of the financing of the economy. The absence of budgeting was reflected in health sector planning. Nonmonetary resources (medicines, medical supplies, hospital beds, and so on) were allocated to MINSAP by JUCEPLAN for distribution to the health institutions at each administrative level. At the national level MINSAP coordinated the sectorial programs with other national-level offices responsible for planning the distribution of nonmonetary resources for health. Also, all activities related to health and planning statistics were integrated into one office.<sup>39</sup>

Until 1970, no annual economic plans were enforced nor was there discussion or arrangements for a 1966-70 medium-range economic plan. In fact, by the end of 1966 the

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<sup>38</sup>. Vicente Navarro, "Health, Health Services, and Health Planning in Cuba," International Journal of Health Services 2 no. 3 (1972): 421. Although this is an outdated review of health and economic planning in Cuba, it is an excellent source of the planning process at the end of the 1960s.

<sup>39</sup>. Arsenio Carmona Gutierrez and Mario Escalona Reguera, El Proceso Investigativo en la Planificación de Salud: Plan de Salud 1981-1985. Conceptos y Metodo (La Habana: MINSAPIDS, 1981), p. 15.

annual plan became a tool for internal calculation and lost its directive nature. JUCEPLAN was limited to research that would assure the output targets fixed by the political leadership. Accordingly, a medium-range planning approach was used with mini-plans for specific sectors, such as sugar, cattle-raising, fishing, and electricity.

The government justified this approach by claiming that there were no statistics or personnel for highly abstract exercises, and that it was better to concentrate scarce resources on the vital sectors of the economy. To solve urgent economic problems, special and extra plans were introduced by the political leadership. The plans were administered and resources allocated by "loyal revolutionaries" outside JUCEPLAN.<sup>40</sup>

The net result of the absence of a central economic plan and lack of coordination was the shortage of inputs, shutdowns, and proliferation of incomplete projects.<sup>41</sup> The absence of an economic management and planning system contributed to the failure to achieve a coherent development strategy and the inability to define the course public health would follow between 1964 and 1970.<sup>42</sup>

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<sup>40</sup>. Ibid., p. 24.

<sup>41</sup>. Ibid.

<sup>42</sup>. Jose L. Rodriguez, "La Economia de Cuba Socialista," p. 138; Gutierrez and Reguera, "EL Desarrollo de la Higiene," p. 308.

At the beginning of the 1970s a far-reaching economic setback occurred which signaled a turning point in the development of economic policy and process. The failure to achieve the ten-million ton "zafra" or sugar cane harvest caused major dislocations throughout the economy.<sup>43</sup> Also, high rates of labor absenteeism and an increasing foreign debt forced a process of self-criticism.

As a result, central planning was reinstated as the main tool of the economy and special priority given to medium-term planning. JUCEPLAN prepared the first economic projections for the 1971-80 decade.<sup>44</sup> Lower-level plans were subordinated to the central plan. Annual macro plans were restored in 1973 and a global economic model was drafted for the 1973-75 period.<sup>45</sup>

The first systematic plan for the health sector was the 1970-80 Health Plan, which was a direct result of reinstating central economic planning as the main tool of the economy in 1970. This health plan made evident many inconsistencies, mainly those related to the information and coordination that was necessary between and within

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43. Marta Harnecker, Cuba: Dictatorship or Democracy (Westport, Conn.: Lawrence Hill & Company, 1980), p. xxvi.

44. Comision Economica para America Latina, "Aspiraciones Sobre el Estilo de Desarrollo y Sobre las Principales Politicas Sociales en Cuba," Economia de America Latina 1 (September 1978): 142.

45. Mesa-Lago, Economy of Socialist Cuba, p. 29.

sectors.<sup>46</sup> Hence it was never used as a directive instrument.

By 1972, the planning unit within MINSAP was modified once more, creating two directive offices. One office planned professional resources and health programs, the other, material and technical resources.

Not until 1975, when the First Congress of the Cuban Communist Party was held, was the first medium-term economic development plan elaborated for the 1976-80 period. Cuba was slow in initiating the planning practices followed by other socialist countries. JUCEPLAN justifies this delay by saying that for the national economic planning process to start a stronger economy was needed in addition to the admission of Cuba into the socialist-block economic group, the Council for Mutual Economic Assistance (CMEA).<sup>47</sup> The First Congress resulted in, (1) a new political administrative structure, (2) Peoples' Power, and (3) a new economic management and planning system.

### Political-Administrative Structure

In 1976, JUCEPLAN and other related government agencies developed a new political-administrative struc-

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<sup>46</sup>. Ibid., p. 16.

<sup>47</sup>. Comision Economica para America Latina, "Apreciaciones sobre el Estilo de Desarrollo y Sobre las Principales Politicas Sociales en Cuba," p. 142.

ture for Cuba.<sup>48</sup> Before 1976, the island was divided into 6 provinces, 58 regions, and 407 municipalities.<sup>49</sup> Political leaders believed that this structure caused an excessive detachment between the national level and the institutions at the base.<sup>50</sup> Thus the number of provinces was increased to 14, the number of municipalities reduced to 169, and the regional level eliminated.<sup>51</sup> See Figure 2.1.

### Peoples' Power

One of the great lessons of the 1970 sugar harvest failure was the sudden awareness that it was impossible even for a socialist state to manage everything centrally. Fidel Castro stressed this point in his July 20, 1970, speech:

It is no longer possible to direct production simply through a Council of Ministers. Why?

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48. The following criteria were used to substantiate the new political-administrative structure: increased power to be delegated to the provincial and municipal levels; ability to simplify planning and management; population distribution; road networks; migration; geographic features; and economic activities. See Mario Escalona Reguera and Nisia Aguero Benitez, La Estructura del Estado Cubano (La Habana, Cuba: MINSAP-IDS, 1981), p. 15.

49. Ibid., pp. 14-15.

50. Tesis y Resoluciones, Primer Congreso del Partido Comunista de Cuba (La Habana: Editorial de Ciencias Sociales, 1978), p. 157.

51. Jose A. Perdomo and Norma Montes, "Las Proporciones Economicas Territoriales en la Republica de Cuba," Cuestiones de la Economia Planificada 3 (March/April, 1980): 105-6.



Because social production depends today on the social administration of public resources. It is impossible today to direct and coordinate this entire apparatus. It is necessary to create a political structure capable of tying together the different sectors of social production.<sup>52</sup>

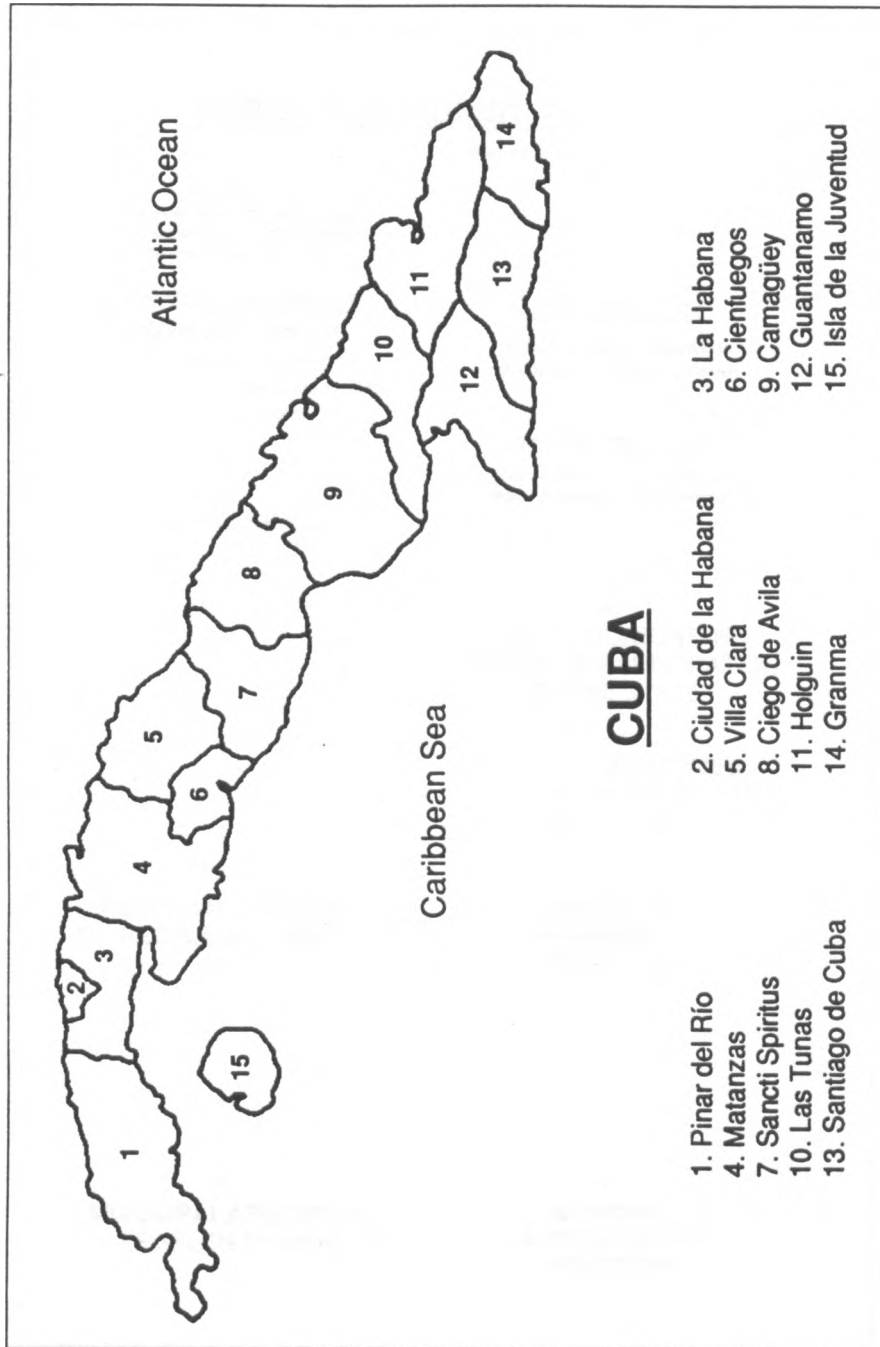
As a result, Peoples' Power was developed in 1974 and implemented islandwide in 1975. The Cuban government regards People's Power as the mechanism for "direct popular participation" in the affairs of the state. Equally, People's Power influenced the development of the new structure of the Cuban state and government, which is diagrammed in Figure 2.2.

In formal terms, legislative, executive, and judicial power converge in People's Power. The legislative function belongs to the National Assembly of Peoples Power (NAPP) which is formed by 480 deputies that represent the 169 municipalities. The deputies are elected for five-year periods and their mandate can be revoked by the electors.<sup>53</sup> The State Council's members are elected by the NAPP. The main function of the State Council is to take over the duties of the NAPP between sessions. At the provincial and municipal levels there are the Provin-

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52. Harnecker, Cuba, p. xxvi.

53. Over 90 percent of the members of the National Assembly of Peoples' Power are also members of the Communist Party. Thus, membership in the National Assembly is an appointment that reflects decisions made by the national leadership and guarantees that major leadership policies will not be challenged. Serious challenges to established policy are made only by those members of a high and secure rank. For more information see Jorge I. Domínguez, "Revolutionary Politics: The New Demands for Orderliness," in Jorge I. Domínguez, ed., Cuba: Internal and International Affairs (Beverly Hills: Sage Publications, 1982), pp 33-34.



**Figure 2.1**  
Political-Administrative Structure of Cuba

**Source:** Ministerio de Salud Pública, Republica de Cuba, Informe Anual a la Asamblea Nacional del Poder Popular (La Habana, Cuba: MINSAP, 1983), p.21

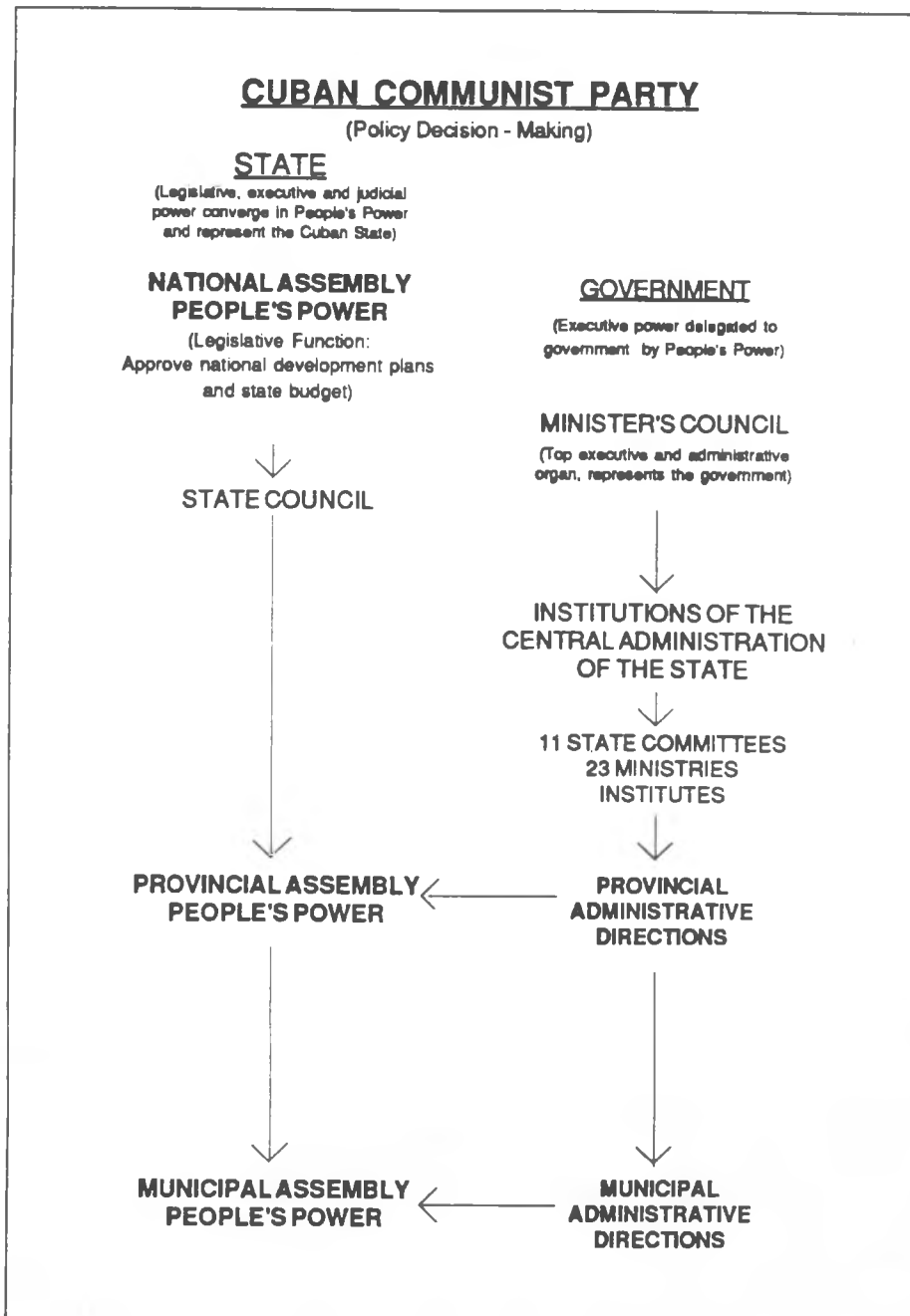


Figure 2.2 Structure of the Cuban State

Source: Mario Escalona Reguera and Nisia Agüero Benítez La Estructura del Estado Cubano (La Habana, Cuba: MINSAP, IDS, 1981), p.25.

cial Assembly of People's Power and the Municipal Assembly of People's Power.<sup>54</sup>

The Cubans see executive power delegated from the state to the government, which is represented by the Ministers' Council. Thus, in the same manner that the leaders regard the NAPP to be the "supreme organ of power of the Cuban state," they regard the Ministers' Council to be the top executive and administrative organ of the Institutions of the Central Administration of the State (ICAS). The ICAS is formed by the ministries, the state committees, and the institutes. As a group, the Ministers' Council and the ICAS constitute the government.<sup>55</sup> Judicial power is assigned to the People's Courts and the Public Prosecutor.<sup>56</sup>

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<sup>54</sup>. Reguera and Benitez, La Estructura del Estado Cubano, pp. 18-19.

<sup>55</sup>. The Ministers Council proposes the general plans for socioeconomic development and the state budget. Once they have been approved by the NAPP, the Ministers Council controls their implementation. Most important, it is one of the key organizations to interlock with top party organs. Of its fourteen members in 1980, eight were members of the Cuban Communist Party Politbureau, one is a Politbureau alternate, and the rest belong to the Cuban Communist Party Central Committee. See Dominguez, "Revolutionary Politics," p. 27.

<sup>56</sup>. Interview with Alejandro Duran, dean of the National and Industrial Economics School, University of La Habana, La Habana, Cuba, November 29, 1983.

## Economic Management and Planning System

In Cuba, the main goal of the Economic Management and Planning System (EMPS) is to increase economic efficiency. Presently, the main strategies used to achieve this goal are import-substitution and promotion of exports; a combination of material and moral incentives to increase work productivity; and improvement of the quality of consumer products.<sup>57</sup> This system combines centralized planning with some economic autonomy within the productive units. The Cuban conception of economic autonomy, however, is that the main economic decisions are taken centrally by the top leadership of the Communist Party, the state, and the government, and the participation of workers at the enterprise level on economic matters is encouraged.<sup>58</sup>

The main tool of the EMPS is planning. To elaborate the Cuban Plan for Economic and Social Development, JUCEPLAN considers three levels: the national economic plan, the sectorial plan, and the enterprise-level plan. These three plans are also drawn up from an institutional, territorial, and branch perspective. Finally, the complete set of plans is formulated within the framework

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57. Hector Ayala Castro and Frank Hidalgo-Gato, "Aspectos Teoricos del Sistema de Direccion y Planificacion de la Economia," Economia y Desarrollo, n.d., p. 42.

58. Direccion de Perfeccionamiento del SDPE de la JUCEPLAN, El Sistema de Direccion y Planificacion de la Economia de las Empresas (La Habana: Editorial de Ciencias Sociales, 1981), p. 4.

of what the Cuban economic planners call the "planning horizons": a long-range plan for a fifteen-year period, a medium-range plan for a five-year period, and a short-range plan for a one-year period.<sup>59</sup> The medium and short-range plans are based on the long-range plan. In 1978 a joint resolution of the Ministers Council and the Communist Party Politbureau proclaimed the beginning of the formulation of the "Long-Range Economic and Social Development Strategy to the Year 2000."<sup>60</sup>

In 1976, when Cuba's new political-administrative structure was implemented, People's Power was established, and the new system of managing and planning the economy was enforced, the structure of MINSAP was modified once more. The planning units were maintained unchanged with the same functions.<sup>61</sup>

In 1977, when activities related to the establishment of the Long-Term Plan to the Year 2000 began under the direction and methodological control of JUCEPLAN, the MINSAP officials responsible for health planning were included. Furthermore, during that year, a Soviet adviser from the Health Policy Directive of the Soviet Ministry of Health was incorporated in MINSAP.<sup>62</sup> In collaboration

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<sup>59</sup>. Interview with Alejandro Duran, November 17, 1983.

<sup>60</sup>. Francisco Martinez Soler, "Hacia una Estrategia de Desarrollo Economico y Social de Cuba hasta el Ano 2000," Cuestiones de la Economia Planificada 8 (March/April 1981): 12.

<sup>61</sup>. Ibid., p. 17.

<sup>62</sup>. Ibid., pp. 17-18.

with the officials of the Health Policy Directive of MINSAP he helped to develop the publication titled Norms, Patterns, and Indexes for the Development of Health until 1985. These norms have become an important tool in health planning activities, specifically for the Second Five-Year Health Plan (1981-1985). Before 1977, norms were not used for programmatic health planning.<sup>63</sup> Once formal and systematic health planning was initiated, Cuba was included in the research projects undertaken by the Council for Mutual Economic Assistance, specifically, in studies related to the development of research methodologies to assess health status and organization of public health.<sup>64</sup> Cuba started using formal, systematic methodologies for health planning in 1977, around the same time it implemented its first national economic plan. Until 1977, its health achievements were obtained through ad hoc, "programmatic" health planning. Therefore, the evolution of health planning in Cuba has resulted from the progressive development of the national economic plan.<sup>65</sup>

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63. Interview with Dr. R. Hernandez Elias, "Health Planning Process in Cuba," health planner, Health Policy Office, Ministry of Health, La Habana, Cuba, July 20, 1983.

64. Gutierrez and Reguera, "El Desarrollo de la Higiene," p. 309.

65. Gutierrez and Reguera, El Proceso Investigativo en la Planificación de Salud: Plan de Salud 1981-1985. Conceptos y Metodo (La Habana, Cuba: Ministerio de Salud-Instituto de Desarrollo de la Salud, 1981), p. 8.

### Improvement in the Health Sector

A constant increase in per capita public health expenditures since sometime in the 1940s can be observed in Table 2.2. Once budgeting was reinstated and efforts were made to establish systematic health planning in the 1970s, expenditures for public health rose to new heights.

The results of the measures taken by the government of Cuba in the area of health care delivery between 1960 and 1982 are seen in Table 2.3. A steady increase in the health care delivery indices is shown in the table, namely number of physicians, hospital beds, and medical visits per capita. When these same health care delivery indices are compared for the fourteen provinces, as is done in Table 2.4, however, important regional disparities are revealed. The promotion of health policies to increase accessibility and distribute health resources equitably has not been as effective as Cuban health officials proclaim.

Table 2.5 shows a uniform increase in life expectancy rates between 1930 and 1982. Rates were already increasing before the revolution in 1959. The same table shows a decrease in infant and general mortality rates, but in this case most noticeable after 1960, when islandwide accessibility to health services was increased. The only health index for which regional variations are available is infant mortality. Table 2.6 shows that from 1979 to 1981 regional variations for infant mortality decreased and they



increased slightly in 1982, although overall the worst case continued to be less bad year after year. Surprisingly, the lowest infant mortality rate in 1979, 1980, and 1982 was registered in the province of Matanzas, not in Havana, as would be expected. The highest infant mortality rate was registered in the province of Guantanamo, which is located in one of the least developed areas of the country.

Since 1960, the major causes of death have changed substantially. Then, 194.6 per cent of deaths were from acute infectious diseases; today only 63.5 per cent are. The shift has of course been to chronic diseases, which have a somewhat higher incidence and loom proportionately much higher. Also, violent deaths such as accidents have become a more important cause of mortality. Table 2.7, shows the gross death rates by cause between 1960 and 1980.

Table 2.2

Public Health Expenditures in Cuba  
1930-1980

Years	Cuba [a]
1930	1.48
1940	1.11
1950	3.67
1960	7.29
1970	29.12
1980	45.35[b]

[a] In Cuban pesos. An artificial currency exchange of 1.35 dollars per Cuban peso has been maintained by the Cuban government.

[b] 1976.

Source: Mario Escalona Reguera, Temas de Administracion Servicios y Programas de Salud Publica (La Habana, Cuba: MINSAP - Instituto de Desarrollo de la Salud, 1983).

Table 2.3

Health Care Delivery in Cuba,  
1960-1982

Years	Physicians per 10,000 inhabitants	Hospital Beds per 1,000 inhabitants	Medical Visits per capita
1960	8.9	4.3	---
1970	7.1	4.6	3.4
1980	15.6	5.5	4.6
1982	17.3	5.9	5.0

Sources: Basic sources for all are Cuba, Ministerio de Salud Publica, Informe Anual 1980, 1981, and 1982 Mesa-Lago, "Alternative Strategies to the Social Security Crisis: Socialist, Market, and Mixed Approaches;" and Diaz-Briquets, The Health Revolution in Cuba, p. 32.

Table 2.4

Regional Disparities[a] for Health Care Delivery  
in Cuba, 1982

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Indicators

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Physicians (x 10,000 inh.)

Range 5.7-18.5[b]

Interval 12.8

Hospital Beds (x 1,000 inh.)

Range 2.6-11.2

Interval 8.6

Medical Visits (per capita)

Range 3.1-7.6

Interval 4.5

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[a] Comparison between the two provinces with the lowest and highest indices for health care delivery. Includes Cuba's fourteen provinces.

[b] 1980.

Sources: Basic sources for all are CUBA, Ministerio de Salud Publica, Informe Anual 1980 and 1982 and Carmelo Mesa-Lago, "Alternative Strategies to the Social Security Crisis: Socialist, Market, and Mixed Approaches," p. 352.

Table 2.5

Evolution of Health Indices in Cuba,  
1930-1982

Years	Mortality Rates		Life Expectancy
	General (per 1,000)	Infant[a]	
1930	10.8[b]	46.4	41.5
1940	---	---	51.0[c]
1950	---	---	58.8[d]
1960	6.3	43.6[e]	61.8
1970	6.3	38.8	68.5
1980	5.7	19.6	73.5
1981	5.9	18.5	72.0
1982	5.7	17.3	73.5

[a] Death of infants under one year of age per 1,000 live births.

[b] 1931.

[c] 1941.

[d] 1953.

[e] 1962.

Sources: Report of the Commission on Cuban Affairs, Problems of the New Cuba (Washington, D.C.: Foreign Policy Association, 1935); Mario Escalona Reguera, Temas de Administracion de Servicios y Programas de Salud Publica; and CUBA, Ministerio de Salud Publica, Informe Anual 1982.

Table 2.6

Regional Variations[a] for Infant Mortality Rates in  
Cuba, 1978-1982

Years	Range	Interval
1979	14.7 - 26.1	11.4
1980	14.0 - 24.1	10.1
1981	14.6 - 23.3	8.7
1982	10.6 - 21.6	11.0

[a] Comparison between the provinces with the lowest and highest infant mortality rates.

Source: Cuba, Ministerio de Salud Publica, Informe Anual 1982, p. 24.

Table 2.7

Mortality by Cause in Cuba, 1959-1980  
(per 100,000 inhabitants)

Change	1960 [a]	1965 [b]	1970	1975	1980	%
Heart Disease	139.0	149.1	148.6	148.3	167.9	
Malignant Tumors	95.0	96.6	98.9	99.3	106.8	
<b>SUBTOTAL:</b>	234.0	245.7	247.5	247.6	274.7	+17%
Infectious and Parasitic	94.4	50.9	45.4	16.9	10.1	
Perinatal	64.4	41.6	41.7	25.2	13.3	
Influenza	35.8	40.7	42.1	38.8	40.1	
<b>SUBTOTAL:</b>	194.6	133.2	129.2	80.9	63.5	-67%
Accidents	29.0	31.9	36.1	33.3	37.7	+3%

[a] 1962.

[b] 1968.

Sources: CUBA, Ministerio de Salud Publica, Informe Anual 1980, 1982; and Mario Escalona Reguera, Temas de Administracion de Servicios y Programas de Salud Publica.

## COSTA RICA

Since 1970, Costa Rica has had outstanding and sustained health improvements. This success is reflected in major health indicators and is significant when compared with other developing countries.

Costa Rica's progress in health care is reflected in the substantial reduction of mortality rates. During the first half of the century, for example, the country's gross mortality rate declined from 30 (1910-20) to 12 per thousand (1950-55).<sup>66</sup> Between 1970 and 1983 the general mortality rate was further reduced by 41 percent, declining from 6.6 to 3.9 per thousand. Furthermore, the infant mortality rate decreased from 61.5 to 18.6 per thousand live births, a 70 percent reduction.<sup>67</sup> As a result, life expectancy has increased from 41 years in 1929 to 56 in 1950 and to 74 in 1982.<sup>68</sup>

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66. Luis Rosero and Hernan Caamano, "Tablas de Vida de Costa Rica, 1900-1980," Mortalidad y Fecundidad en Costa Rica (San Jose, C.R.: Asociacion Demografica Costarricense, 1983), p. 10.

67. Lenin Saenz, "Health Changes during a Decade: The Costa Rican Case," in Scott B. Halstead et al., eds., Good Health at Low Cost (Proceedings of a Conference held in Bellagio, Italy, April 29-May 3, 1985, sponsored by the Rockefeller Foundation), p. 247.

68. Claudio Gonzalez-Vega, "Health Improvements in Costa Rica: The Socioeconomic Background," in Scott B. Halstead et al. (eds.) Good Health at Low Cost (Proceedings of a Conference held in Bellagio, Italy, April 29 - May 3, 1985, sponsored by The Rockefeller Foundation), p. 263.



But mortality rates have not been uniform. As of 1973, there was a seven-year difference between the province with the lowest and the three provinces with the highest life expectancies. Moreover, although the reduction in infant mortality rates has been very significant, particularly if one considers the low incidence of abortion, it is not uniform nationwide.<sup>69</sup> Infant mortality rates have been traditionally higher for children living in areas where standards of living are lower, that is, outside the Central Valley, which until 1979, had the lowest infant mortality rate.<sup>70</sup>

During the 1970s, the expansion of infrastructure, and of public and health services in rural areas determined improvement in health standards. During that decade, three-fifths of the population lived in rural areas, two-fifths lived in urban areas.<sup>71</sup> The introduction of sanitation, immunization, and mother-infant care services helped control diarrheal diseases and respiratory infections. As a result, infant mortality rates declined.

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<sup>69</sup>. Luis Rosero, "Notas Acerca del Aborto en Costa Rica," Mortalidad y Fecundidad en Costa Rica (San Jose, C.R.: Asociacion Demografica Costarricense, 1983), p. 87.

<sup>70</sup>. Juan Jaramillo Antillon, Los Problemas de la Salud en Costa Rica: Politicas y Estrategias (San Jose, C.R.: Organizacion Panamericana de la Salud, 1984), pp. 23-24. See also Luis Rosero and Doris Sosa, "La Mortalidad Temprana en los Cantones de Costa Rica, 1968-1969," Mortalidad y Fecundidad en Costa Rica, pp. 21-22.

<sup>71</sup>. Oficina de Planificacion Nacional y Politica Economica, Evolucion Socioeconomica de Costa Rica 1950-1980 (San Jose, C.R.: EUNED, 1982), p. 213.

These good health conditions, along with many other positive aspects of social life, did not come easily to Costa Rica. Its history in the last century has been punctuated with dramatic events of social conflict, including the 1871 coup followed by the dictatorship of Tomas Guardia, the popular insurrection in 1919 that Julio Acosta took to power, the violent 1934 banana strike, and the civil war of 1948.

### Historical Evolution

For nearly four centuries after the Spaniards settled in Costa Rica, it remained isolated, and its scarce population was concentrated in the Central Valley.<sup>72</sup> From the sixteenth century to the mid-nineteenth century the lack of minerals and a small Indian population made Costa Rica one of the poorest and most remote Spanish territories in America. An agricultural subsistence economy emerged based on small family landholdings. Democratic principles in Costa Rica are said to be the result of isolated farmers in the colonial times having to work

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72. Richard Biesanz et al., The Costa Ricans (Englewood Cliffs, N.J.: Prentice-Hall, 1982), p. 14.

their own land for lack of Indians to use as labor power or of precious metals to export.<sup>73</sup>

By the mid-nineteenth century, the pattern of "coffee power" was established, and from 1860 to 1913 an oligarchy with "liberal" economic ideas ruled the country. Coffee exports integrated Costa Rica into the world market. Although the coffee oligarchy controlled processing and marketing, production was controlled by small landowners. In 1871, after a successful coup, Colonel Tomas Guardia came to power and curbed the economic control of the upper-class coffee barons. He levied high taxes and spent tax revenues on education, public health, and transportation including the Atlantic railroad. This railroad, built to transport coffee from the Central Valley to the Caribbean Coast, led to the development of another export product even more dependent on foreign investments and markets, bananas.<sup>74</sup> The production and export of bananas were controlled by foreign multinational corporations, particularly the United Fruit Company. This situation resulted in colonization of tropical jungles in the

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<sup>73</sup>. Claudio Gonzalez-Vega, "Health Improvements in Costa Rica: The Socioeconomic Background," in Halstead et al. eds., Good Health at Low Cost, p. 264. See also Luis Rosero, "Las Politicas Socioeconomicas y su Efecto en el Descenso de la Mortalidad y Fecundidad en Costa Rica," Mortalidad y Fecundidad en Costa Rica, p. 38.

<sup>74</sup>. Biesanz et al., Costa Ricans, p. 20.

lowlands and the investment of North American capital.<sup>75</sup> Costa Rican coffee producers were reluctant to invest large amounts of capital to make malarial swamps and tropical jungles habitable. Costa Rican laborers used to the temperate zone were unwilling to work in the tropical area and forced the banana companies to import black workers from the West Indies as well as Chinese workers. Thus the banana producing areas of the Limon province on the Caribbean coast grew up as isolated enclaves under foreign control and remained so for decades. The railroad promoted the transformation of the old subsistence economy to a specialized commercial-agricultural economy dependent on foreign nations, mainly the United States and Britain.

In 1889, a group called the "generation of 1889" improved educational conditions, proclaiming that primary education should be free, compulsory, and secular. Richard Biesanz explains:

During Guardia's dictatorship, a group of young men banded together to study and discuss republican principles and liberal ideas. After Guardia's death in 1882 this "generation of 1889" ushered in a new stage in Costa Rican history, a shift from "patriarchal" to "liberal" democracy. They believed that Church and state should be separate, with the state dominant, and that formal education would solve the problems of individuals and the nation. The parties that formed around prominent members of this group were based on personal appeal rather than on programs and ideologies. Violence, the monopoly of power by the elite, and electoral fraud by no means disappeared during the decades of

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<sup>75</sup>. Luis Rosero, "Las Politicas Socioeconomicas y su efecto en el Descenso de la Mortalidad y Fecundidad en Costa Rica," Mortalidad y Fecundidad en Costa Rica, op.cit., p. 38.

their influence, nor did the lower classes have any power over the political process or much interest in it. But a free press increasingly guided public opinion, and Costa Ricans became accustomed to listening to educated people speak in the name of ideas and reason.<sup>76</sup>

During the first part of the twentieth century Costa Rica was ruled by a conservative elite that promoted laissez-faire in both economy and society.<sup>77</sup> Between 1913 and 1947, however, economic vulnerability to internal and external factors and a series of economic crises led to impoverishment. The emerging middle class became frustrated, small farmers lost their land, and salaried workers lost their jobs or saw their income reduced. As a result, social harmony was disrupted and popular revolts broke out. For example, in 1919, popular insurrection brought the government of Julio Acosta to power. Then in 1921, low salaries and inadequate job conditions triggered a nationwide workers' strike. Acosta suddenly became aware that growing social problems posed a threat to social order, and he implemented pension programs for some government workers. He also created the Hygiene and Public Health Office in 1922. This was the first time the state intervened in matters dealing with preventive health in Costa Rica. Before 1923, the most important institution involved in preventive health activities was the Rockefeller Foundation, which had come to Costa Rica to

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76. Biesanz et al., Costa Ricans, p. 21.

77. Mesa-Lago, "Alternative Strategies to the Social Security Crisis," p. 333.

organize hygiene and public health programs.<sup>78</sup> In 1927, the Hygiene and Public Health Office became the Ministry of Health. At the time, the major health issue was the control of smallpox and epidemics. The most important health-related event to occur during the 1920s, however, was the passage of the Public Health Protection Law in 1923. This law stipulated which diseases had to be reported to the health authorities and assigned each municipality specific hygiene and health tasks. Municipalities were obliged to assign 15 percent of their income for such activities. This law also brought under state control all hospitals and health centers created and supported by private organizations involved in charity.<sup>79</sup>

The most notorious of the popular revolts of the first half of the twentieth century was the 1934 banana strike. As mentioned earlier, the banana-producing areas were mostly tropical jungles and swamps heavily infested with malaria. As a result, in 1928 an antimalaria campaign was implemented. The banana union also forced the establishment of the banana company hospital system. The first sanitary units of the Ministry of Health replaced "town physicians" in the delivery of health services to the population. During the 1930s, health programs dealing with environmental health, drugs, foods, and beverage

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<sup>78</sup>. Mark Rosenberg, Las Luchas por el Seguro Social en Costa Rica (San Jose, C.R.: Editorial Costa Rica, 1983), pp. 30-32.

<sup>79</sup>. Luis Rosero, "Las Politicas Socioeconomicas y su Efecto," p. 57.

control expanded the preventive health actions implemented during the 1920s.<sup>80</sup> Throughout the 1920s and 1930s the economically powerful groups steadfastly opposed social and health programs. Progressive individuals from opposing political parties, however, strong enough to be taken seriously within the power structure, were given important positions in the government. These individuals promoted the implementation of health programs. Thus the period 1900 to 1939 was characterized by the introduction of hygiene and public health programs.<sup>81</sup> Yet before 1939 there were few integrated and well-planned state interventions in social problems. The main reason for the lack of integration and planning was the noninterventionist political style prevalent at the time.<sup>82</sup>

In the early 1940s, the government of Dr. Rafael Calderon Guardia, a physician and the president of Costa Rica, introduced some important social changes, including the enactment of a labor code that guaranteed workers the right to organize, protected them against arbitrary dismissal, set a minimum wage, and made collective bargaining mandatory. In addition, he secured the passage of a law that allowed the landless to acquire title to unused land

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<sup>80</sup>. Ibid., p. 58.

<sup>81</sup>. Edgar Mohs, La Salud en Costa Rica (San Jose, C.R.: Editorial Universidad Estatal a Distancia, 1983), p. 37.

<sup>82</sup>. Rosenberg, Las Luchas, p. 44.

by cultivating it.<sup>83</sup> The most important health-related achievement of this decade was the creation of the Costa Rican Social Insurance Fund (CCSS). Mark B. Rosenberg, author of the best historical and political analysis of the CCSS asserts that Calderon Guardia

was deeply moved by the high degree of social misery in which most Costa Ricans lived and to which they had become accustomed. But, he was also aware of the growing influence of Communism within Costa Rica and worldwide. Calderon Guardia considered that Catholic ideas dealing with social reform were not only the best manner of eliminating social misery, but also and maybe most importantly they offered a valid alternative to the Communist threat.<sup>84</sup>

Implementing the CCSS was not an easy task for many powerful groups within Costa Rican society opposed it. The CCSS began offering medical and maternity insurance to selected classes of workers, including pension programs financed jointly by workers, employers, and the government. By 1948, the CCSS health-care program reached 20 percent of the economically active population.<sup>85</sup> The health programs offered by the Ministry of Health were continued throughout the 1940s, with special attention to the malaria campaign. These events eroded the power of the old elite and started Costa Rica on the path to social democracy.

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<sup>83</sup>. Mario Hidalgo Brenes, Dr. Rafael Calderon Guardia, Reformador Social de Costa Rica (San Jose, C.R.: Imprenta Borrased, 1983), pp. 37-54.

<sup>84</sup>. Ibid., p. 48.

<sup>85</sup>. Claudio Gonzalez-Vega, "Health Improvements in Costa Rica: The Socioeconomic Background," in Halstead et al., eds., Good Health at Low Cost, p. 266.



The civil war of 1948 marked a turning point in Costa Rican history. The uprising directed by Jose Figueres and the National Liberation Party (PLN) and their subsequent victory gave them power over the direction of Costa Rican society for the next three decades. Their social democratic scheme was based on commitment to government-guided development and social justice through a welfare state. The state became bigger and more powerful by controlling key sectors of the economy such as banking, energy, and insurance. The state also promoted development by using protectionist policies; it became the largest employer and the biggest user of resources to provide public services. But no radical change occurred in the economic power structure because development policies favored private investors. Yet a large middle class had emerged, and per capita GNP increased from \$340 in 1947 to over \$900 in 1979. Thus social policies were used to redistribute the benefits of growth (notably in health and education) to those who stood to lose from the concentration of wealth and income, at least until the financial crisis of the early 1980s.

By 1950, as a result of the changes brought about by the 1948 civil war and the social democratic scheme that followed, the Ministry of Health was reorganized and two departments were created, the Delivery of Health Care Office, in charge of all matters concerning hospital care, and the General Health Office, which coordinated preventive health programs. The CCSS also widened coverage to

include the relatives of salaried workers. The achievements in health care during the 1950s were influenced by an increase in the standard of living and particularly by the arrival of new technologies to diagnose and cure tuberculosis and malaria. Massive vaccination programs against polio, typhoid fever, diphtheria, and smallpox were implemented. Nutrition centers to distribute food to preschool children and mothers as well as school lunch programs were made available in practically all schools. Less emphasis was given to curative hospital care than to ambulatory care and preventive medicine.

A lull in health achievements occurred in the 1960s. Although health programs were continued and intensified they were not as effective. The time when important results could be achieved at low cost simple measures had ended. However, some significant events occurred such as the establishment of the medical school and the Costa Rican Institute of Water and Sewers in 1961. In 1961, the influence of the Alliance for Progress stimulated a program of socioeconomic reform and a constitutional amendment that ordered social security to be universal in ten years.<sup>86</sup> In 1964, massive vaccination programs against measles were implemented and the National Children's Hospital was established. Yet the CCSS remained stagnant, protecting a very small proportion of the labor

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<sup>86</sup>. Mesa-Lago, "Alternative Strategies to the Social Security Crisis, p. 337.

force in urban areas, mainly in the capital city of San Jose.

Until 1970, the Ministry of Health and the CCSS waged a power struggle. Eighteen uncoordinated institutions constituted the health sector. Communities with fewer than two thousand inhabitants did not have health centers, and 90 percent of health resources were spent on curative medicine.<sup>87</sup> The existence of multiple health care delivery institutions, lack of coordination, and duplication of services formed the background out of which a policy of sectoral integration through a national health plan was adopted in the 1970s.<sup>88</sup> The Ministry of Health transferred to the CCSS the tasks dealing with hospital administration and focused on the development of public health programs, including vaccination against infectious diseases, environmental health, and latrinization of rural areas. The most important program established in the 1970s was the Rural Health Program (RHP), which benefited dispersed rural populations through preventive and curative actions as well as health education. The RHP started in 1973 under the policy of "extension of coverage of basic health services"

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87. Edgar Mohs, La Salud en Costa Rica (San Jose, C.R.: Editorial Universidad Estatal a Distancia, 1983), p. 160.

88. Ibid., p. 54.

based on the "simplified medicine" concept.<sup>89</sup> An equally important program of the 1970s was the Community Health Program (CHP) patterned after the RHP and implemented in 1976 for the urban poor. Finally, since 1975 the Social Development and Family Subsidy Law has allocated funds to finance feeding and nutrition programs. Priority has been given to nutrition education, epidemiological surveillance of nutritional status, and complementary feeding to infants and pregnant and breastfeeding women.<sup>90</sup>

The previous discussion leads to the conclusion that Costa Rican medicine and health care are to a great degree socialized. There are only three private hospitals and only 3 percent of physicians are in private practice; the remainder in state institutions.<sup>91</sup> But, the development of health care in Costa Rica has not resulted from a commitment to socialism. Mark Rosenberg argues,

In this case, the political and bureaucratic elites have been mostly responsible for provid-

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<sup>89</sup>. In 1971, before the enactment of the rural health program, a project known as "simplified medicine" provided care in rural areas. The Ministry of Health trained community volunteers for a three-month period in first-aid care, vaccinations, environmental health, care of school-aged children, and other similar activities. Health caravans visited some villages once a month. This project was discontinued because of opposition from the boards of some professional associations in the health field. For more information see Lenin Saenz, "Health Changes during a Decade: The Costa Rican Case," in Halstead et al., eds., Good Health at Low Cost, p. 250.

<sup>90</sup>. Ibid., p. 252.

<sup>91</sup>. Ibid., p. 59.

ing the social welfare programs Costarricans enjoy today.<sup>92</sup>

Dr. Juan Jaramillo Antillon, former minister of health, explains,

The importance given to the health sector by those in power in Costa Rica is a direct result of the need to establish harmony among social classes through the promotion of social welfare programs.<sup>93</sup>

The efforts of the elite to maintain unity among social classes has resulted in a dramatic increase in state intervention in health. The CCSS provided 20 percent of the country's health care in 1948 and 80 percent in 1977. Moreover, health-care costs have soared because of (1) an increase in extension of coverage between 1971 and 1977, (2) expansion of welfare programs, and (3) inflation.<sup>94</sup> Social security expenditures as a percentage of GNP doubled between 1969 and 1979. Table 2.8 shows the steady increase in per capita public health expenditures in Costa Rica after 1950. In 1979, the CCSS system ended with a net deficit, and in 1980 an array of austerity measures was introduced. Yet increases in salaries and in the costs of goods and supplies resulting from high inflation in 1889, primary education was declared free, compulsory, and

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92. Rosemberg, Las Luchas, p. 184.

93. Interview with Dr. Juan Jaramillo Antillon, minister of health, 1982-86, Ministry of Public Health, San Jose, Costa Rica, June 9, 1985.

94. Herman Vargas Martinez, "Análisis del Gasto en Salud en el Sector Público de Costa Rica (1957-1977)," Revista Centroamericana de Ciencias de la Salud 5, no. 12, (1979): 147.

Table 2.8

Public Health Expenditures in Costa Rica,  
1930-1980

Years	U.S. dollars, 1970
1930	11
1940	15
1950	8
1960	14
1970	37
1980	65

Sources: Luis Rosero-Bixby, "Determinantes del Descenso de la Mortalidad Infantil en Costa Rica," Demografia y Epidemiologia en Costa Rica, 1985; and Juan Jaramillo Antillon, Los Problemas de la Salud en Costa Rica (San Jose, C.R.: O.P.S., 1984).

a state responsibility; in 1949, free education was expanded to include the secondary level. By 1912 the illiteracy rate in the population ten years of age and older had been reduced to 30 percent. By 1973, illiteracy had been further reduced to 10 percent nationwide, 4 percent in urban areas and 15 percent in rural areas. Allocations to education increased from 25 percent of government expenditures in the late 1950s to 35 percent in the late 1960s and declined to 25 percent in the late 1970s as other social expenditures grew faster.<sup>95</sup>

The structure of income distribution in Costa Rica, though socially acceptable if compared with the rest of Latin America, still suffers from important inequalities. For example, in 1961, 20 percent of all families in Costa Rica lived below the poverty level and received 6 percent of the GNP; in 1971, they received 5.4 percent; and in 1977, 3 percent. In contrast, the top 20 percent of families with the highest incomes received 50 percent of the total GNP

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<sup>95</sup>. Costa Rica from ECLA, Statistical Yearbook for Latin America 1979, p. 37.

in 1961 and 55 percent in 1977.<sup>96</sup> A tendency toward concentration of income over time is obvious.<sup>97</sup>

By 1980, an acute economic crisis characterized by declining output, growing unemployment, rampant inflation, currency devaluation, large public-sector deficits, and a huge external debt became evident. As a result, political stability has been dangerously affected.<sup>98</sup> Because of persistently unbalanced trade and the difficulty in obtaining international financing, a myriad of economic and stabilization policies were established in 1982 by the government and international financing institutions. The limitations imposed by this crisis have resulted in an increasing proportion of resources going to state-sectors with the benefits failing to reach target populations.

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<sup>96</sup>. It must be clarified that income distribution figures over time for Costa Rica are derived from diverse sources and are not comparable given the different methods used for their elaboration. However, they are the only information available and are used to illustrate the probable evolution of income distribution between 1950 and 1980. For more information see, Oficina de Planificacion Nacional y Politica Economica, Evolucion Socioeconomica de Costa Rica, 1950-1980 (San Jose, C.R.: Editorial Universidad Estatal a Distancia, 1982), p. 186.

<sup>97</sup>. Juan Manuel Villasuso Estomba, "Evolucion de la Crisis Economica en Costa Rica y su Impacto sobre la Distribucion del Ingreso," Costa Rica Hoy: La Crisis y sus Perspectivas (San Jose, C.R.: Editorial Universidad Estatal a Distancia, 1984), p. 207.

<sup>98</sup>. Jorge Corrales Quesada, "La Crisis de la Economia Costarricense: Regla versus Autoridades," Costa Rica Hoy, p. 37.



## Early Efforts in Economic and Health Planning

In Costa Rica, the period before 1963 was the era of economic policy without public planning. The economic and social achievements of this period were based on a high degree of improvisation in the formulation of policy and program execution. No institution existed to coordinate public sector actions.<sup>99</sup>

The era of state economic planning started with the creation of the Alliance for Progress in the early 1960s. When the Alliance started the flow of foreign financing to Costa Rica it was conditioned on the implementation of planning techniques and systems.<sup>100</sup> Moreover, the Planning Office (OFIPLAN)<sup>101</sup> was created because the Alliance required it, and development plans were drawn because they were needed to obtain international financing.<sup>102</sup>

At the time, the economic strategy followed was industrialization based on import substitution. This was the strategy promoted by the Economic Commission for Latin

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<sup>99</sup>. Johnny Meono Segura, "Planificacion," in Administracion Publica (San Jose, C.R.: Editorial Universidad de Costa Rica, 1982), p. 106.

<sup>100</sup>. Michael P. Todaro, Economic Development in the Third World (London: Longman, 1977), p. 337.

<sup>101</sup>. OFIPLAN became the Ministry of Planning (MIDEPLAN) in 1979. Thus I will refer to OFIPLAN as MIDEPLAN if the subject discussed occurs after 1979.

<sup>102</sup>. Segura, "Planificacion," p. 106.

America (ECLA).<sup>103</sup> They soon realized, however, that industrialization required a minimum-sized market or a certain level of demand to justify the investment. This posed an important problem for Costa Rica and the remaining Central American countries characterized by small markets. As a result, the policy of the Central American Common Market (CACM), of economic integration was developed, and a regional market, was established.<sup>104</sup>

Both ECLA and the Alliance based their work on "structural" economic theory.<sup>105</sup> In addition, both required economic planning to rationalize the use of resources. By 1965, Costa Rica (and other Central American countries) completed their first medium-term plan, which covered the years 1965-68 and proposed import substitution. The specific goals of the plan were to improve trade conditions and reduce dependency on foreign trade; to transform the structure of Central American economies to assure economic unity and balanced growth; and to guarantee more

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103. Eduardo Lizano Fait, "Los Modelos Economicos: sus Alternativas" in O. Barahona Streber et al., Los Problemas Economicos del Desarrollo en Costa Rica (San Jose, C.R.: EUED, 1980), p. 121.

104. Ibid., p. 122.

105. Structural economic theory contends that underdevelopment is caused by economic rigidities in the structural and/or institutional structures of Third World countries that have their origins in both domestic and international dualistic situations. As a result, they are caught up in a 'dependence' and 'dominance' relationship to rich countries. This theory rejects the exclusive emphasis on accelerating the growth of GNP as an index of development. For more information see Todaro, Economic Development in the Third World, pp. 55-56.

equitable income distribution.<sup>106</sup> At the time, however, the formulation of medium-term plans was the priority. Moreover, there was no relationship between economic policy decision making and the national development plan.<sup>107</sup>

The 1949 Constitution had granted total administrative autonomy to public enterprises. As a result, under the first Planning Law in 1963 such enterprises did not participate in the planning process. Some had their own planning units and their only obligation was to send a copy of their plans to OFIPLAN.<sup>108</sup> Despite these difficulties, some experience and skills were developed for formulating plans. Important statistical information not available before was compiled for reports, short-term plans, and research dealing with economic alternatives for Costa Rica. Most important, the elaboration of public investment plans by OFIPLAN was institutionalized, particularly those plans dealing with industry and agriculture.

The 1969-72 Development Plan proposed a development model based on agro exports instead of import-substitu-

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<sup>106</sup>. Claudio Soto Badillo, Algunos Comentarios en Relacion con la Experiencia de la Vinculacion de Planes a Largo, Mediano, y Corto Plazo en Costa Rica (San Jose, C.R.: OFIPLAN, 1978), pp. 2-3.

<sup>107</sup>. Ibid., pp. 4-5.

<sup>108</sup>. Wilburg Jimenez Castro, Importancia de la Planificacion para el Ordenamiento y Coordinacion de las Actividades de las Empresas Publicas dentro de un Enfoque Sistemico Nacional (San Jose, C.R.: OFIPLAN, 1978), p. 3.

tion. It was founded on studies completed by national and foreign technicians and consultants, but it was developed in such complex econometric terms that only those few who understood econometrics could comprehend it. Despite this limitation, according to Wilburg Jimenez Castro, former minister of MIDEPLAN, this plan showed that

even though the import-substitution process had been intensified, their composition by type of goods; i.e., capital, intermediate, and consumption, was not changed. This phenomenon is explained by the fact that in great part the substitution was of intermediate goods for raw materials with a lower degree of elaboration, such as wheat flour for wheat grain, fuel and lubricants for semirefined petroleum, and so on.<sup>109</sup>

Between 1963 and 1974 the first attempts at regional planning occurred in Costa Rica, primarily concerning projects for the industrial development of backward regions. A considerable part of the periphery was included in regional plans; in fact, some regions were included in more than one plan. These plans were drawn up by national and foreign agencies. After the first analysis was completed, however, the process stagnated and some proposals were never implemented. The total dependency of these projects on foreign agencies and lack of local support explains the failure to implement them.<sup>110</sup>

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<sup>109</sup>. Castro, Analisis del Proceso de Planificacion Nacional, p. 1.

<sup>110</sup>. Carolyn Hall, Costa Rica: Una Interpretacion Geografica con Perspectiva Historica (San Jose, C.R.: Editorial Costa Rica, 1984), p. 386.

As a result, OFIPLAN became aware of the need for a new strategy toward regional planning.

In 1972, a German consultant to the government of Costa Rica, Dr. Helmut Nuhn, proposed that one entity be created and held responsible for integrated regional planning. He defined planning and administrative regions that would replace the existent hierarchy of administrative areas. The first official planning regions established by OFIPLAN in 1975 were based on his study.

In 1974, a new planning law was enacted which replaced the 1963 law and created the National Planning System. Most important, for the first time in Costa Rica systemic criteria for planning were formulated.<sup>111</sup> Institutions were established to integrate the multiple planning systems existent before 1974. This occurrence had strong implications for the future development of the health planning system because a multisectoral emphasis to health and development planning was introduced.

The 1974-78 National Development Plan was the first to include specific proposals for regional planning.<sup>112</sup>

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<sup>111</sup>. Mario Carvajal Robles, "Estudio Comparativo de los Planes Nacionales de Desarrollo" in Castro, Analisis del Proceso de Planificacion Nacional, p. 3.

<sup>112</sup>. Hall, Costa Rica, p. 388.

It promoted import substitution; however, the substitutions were made for raw materials from the national or Central American agricultural sector.<sup>113</sup> The National Liberation Party (PLN) was in power from 1970 to 1978, and it promoted agricultural production for the internal market because the import-substitution model had declined in vigor.<sup>114</sup> This plan placed special emphasis on getting support from all social sectors for its implementation; yet it had no mechanisms for increased popular participation. Furthermore, neither the 1969-72 nor the 1974-78 plan included specific programs to translate medium-term goals into concrete actions, which added to the problem of lack of correlation between plan and action. Also, the inability to establish regional planning as a process in Costa Rica has contributed to the incapacity to establish health planning at the regional level.

The implications of creating the National Planning System as it relates to the elaboration of the 1974-78 plan are unclear. The limited tangible results obtained from this plan suggest that it was an effort to rationalize state interventionism. This is a strategy often used by the PLN. In fact, there is a definite relationship between the start of planning (both economic and health planning) in Costa Rica, the growth of the state sector,

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<sup>113</sup>. Pochet, "Crisis e Historia Economica y Social en Costa Rica," p. 21.

<sup>114</sup>. Ibid.

and the availability of foreign financing for development. For example, the multiple health institutions that emerged in Costa Rica through time brought about uncoordinated growth of services, which were wasteful of resources and inefficient. Not until the 1970s was a unified state health policy clearly defined. Although compliance with such a policy was not always achieved, it did help orient the health sector, despite the difficulties of interinstitutional coordination.<sup>115</sup>

After 1970, the health sector was reformed by the passage of a law that expanded social security coverage to the entire working population, providing the right to sickness and maternity benefits. Health sector policy makers became increasingly concerned with the rational use of resources. Such concern was manifest through policy support for planning processes and institutional development.<sup>116</sup> Thus, in 1971 various research projects dealing with the country's health situation such as new demands for health care, availability of human and material resources, and degree of coordination of services were executed. These projects provided the data to elaborate a health profile and the first National Health Plan for

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<sup>115</sup>. Lenin Saenz et al., Salud en Costa Rica (Evaluacion de la Situacion en la Decada de los Anos 70) (San Jose, C.R.: Ministerio de Salud, Unidad de Planificacion, 1981), p. 1.

<sup>116</sup>. Edgar Mohs, Salud, Medicina y Democracia (San Jose, C.R.: Universidad de Costa Rica, 1980), p. 180.

Costa Rica.<sup>117</sup> Such a health plan was elaborated in 1973 by the Ministry of Health in coordination with the CCSS.<sup>118</sup> A rational use of resources motivated the formulation of the first National Health Plan for the 1974-80 period. Besides economic efficiency, however, this health plan provided the conceptual framework for the programs implemented during the plan period. The main policy embodied in the plan was the delivery of health services to the entire population regardless of socioeconomic status and geographic area.<sup>119</sup> Two basic strategies were used: extension of coverage of services to beneficiaries of the CCSS, and extension of coverage to populations who traditionally had lacked such services, particularly the dispersed rural population and the marginal urban population.

This second strategy was implemented through the rural health and the community health programs. The specific goals were to (1) control infectious diseases through vaccination; (2) reduce morbidity and mortality resulting from malnutrition; (3) improve environmental health, (4) promote family planning; and (5) create a national health system.<sup>120</sup>

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117. Edgar Mohs, La Salud en Costa Rica (San Jose, C.R.: Editorial Universidad Estatal a Distancia, 1983), p. 44.

118. Saenz et al., Salud en Costa Rica, pp. 3-4.

119. Ibid., pp. 1-2.

120. Mohs, Salud, Medicina, y Democracia, p. 160.



The data obtained in 1971 for Costa Rica's health profile showed eighteen institutions in the health sector. One group of these, the Social Protection Councils, were formed by twenty-nine organisms whose only commonality was their demands for state funds and their eagerness to defend their autonomy in all remaining aspects.<sup>121</sup> Hence a policy to support institutional coordination through regionalization of health services was enacted by health policymakers and planners.<sup>122</sup> A direct outcome of the elaboration of the national health plan was that in 1977, the National Commission for Human Resources was constituted to determine the future needs of the health sector.<sup>123</sup>

Goals delineated in the health plan were promoted through political support for health-related legislation. For example, the General Health Law defined future relations between the state, enterprises, and individuals. The Ministry of Health became responsible for the definition of national policies related to planning, coordination, and control of public and private health-related activities.<sup>124</sup>

Once a new government administration came into power in 1978, a new set of regions was established by OFIPLAN

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121. Lenin Saenz, Hacia un Sistema Nacional de Salud en Costa Rica (San Jose, C.R.: Ministerio de Salud, 1983), p. 17.

122. Saenz, Salud en Costa Rica, pp. 4-5.

123. Mohs, La Salud en Costa Rica, pp. 49-50.

124. Ibid.

based on population density, territorial extension, and homogeneous economic production.<sup>125</sup> These regions were the foundation of the construction of the 1979-82 National Development Plan, which emphasized the agro-export model. The new administration argued that the import-substitution model should be abandoned because of the narrow market size, inadequate competitiveness, dependency on foreign inputs and technology, and scarce capacity to generate employment. Moreover, the government argued that the traditional agricultural sector should remain the mainstay of the economy with industry a secondary activity to be stimulated.<sup>126</sup> The rationale was that the agricultural sector held true comparative advantage in trade. Thus the agricultural and livestock sector was and continues to be the main source of foreign currency and contributes largely to financing industrial development.<sup>127</sup>

In 1978, the Public Administration General Law modified the political and legal norms that dealt with institutional autonomy. The ministers, jointly with the president of Costa Rica, were to direct and coordinate not only the central but also the decentralized administration of the state. Based on the National Planning Law and the

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<sup>125</sup>. Hall, Costa Rica. p. 392.

<sup>126</sup>. Mario Cravajal Robles, "Estudio Comparativo de los Planes Nacionales de Desarrollo" in Castro, Analisis del Proceso de Planificacion Nacional, p. 4.

<sup>127</sup>. Ibid., p. 5.

Public Administration Law, an executive decree created the Sectoral Planning Subsystem, which defined the sectors of activity. Nine sectors were established including one for health. Each sector would consist of the ministers of the institutions forming the sector, decentralized institutions, programs, and any other entities related to the same area of activity. In addition, one institution would be assigned to each sector to formulate sectoral policy. This entity would have more power than any of the institutions forming the sector to guarantee coordination, control, and evaluation of the tasks of the sector. To aid in its sectoral policy-making role, planning units were established in each institution forming the sector and in each sector. In 1979, the Constitution for the Health Sector determined that the health sector would consist of (1) the Ministry of Health, (2) OFIPLAN, (3) CCSS, (4) Costa Rican Institute of Water and Sewers, and (5) the National Institute of Health.<sup>128</sup> In 1983, the decree creating the Management and Planning Sectoral Subsystem replaced the Sectoral Planning Subsystem. In this manner, the framework for coordinated health planning emerging from the top of the health sector was established. But lack of coordination prevailed not only at the institutional level, but also in the execution of programs.

Costa Rica's present political-administrative structure includes four levels: the state, the province,

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<sup>128</sup>. Ibid., p. 41.

the canton or municipality,<sup>129</sup> and the district (see Figure 2.3). Although new municipalities and districts are being created, a radical reform to adapt the administrative structure to the changing politics and economy has not occurred. Carolyn Hall argues that the present political-administrative structure no longer provides an efficient base for local government and instead is an obstacle for planning and regional development.<sup>130</sup> Moreover, despite the four administrative levels, in reality, public administration is executed through the centralized national government. The minimal nature of functions delegated and resources supplied to the provinces and municipalities underscores the authority of the central government. Accordingly, national government expenses exceed by thirty-six times those of all municipalities.<sup>131</sup>

The organization of Costa Rica's economic planning system can be seen in Figure 2.4. The system is formed as follows: (1) the political management and policy-making functions are executed by the president of Costa Rica and the Government Council; (2) MIDEPLAN is the central and normative planning institution in charge of political-technical coordination; (3) the Regional Planning Subsystem, the Sectoral Planning Subsystem, and the Adminis-

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<sup>129</sup>. In Costa Rica, a municipality is referred to as canton.

<sup>130</sup>. Hall, Costa Rica, p. 374.

<sup>131</sup>. Ibid.

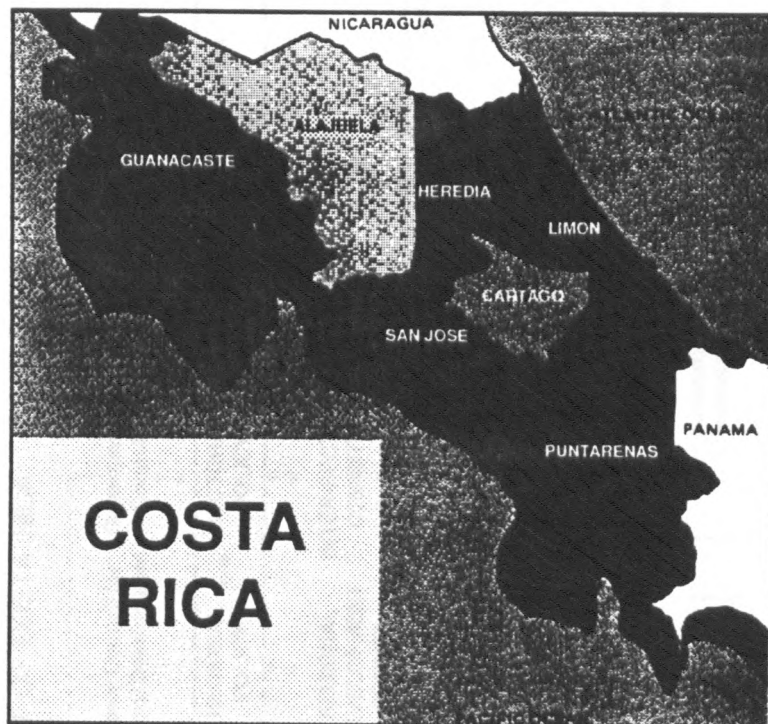


Figure 2.3  
Political-Administrative Structure of Costa Rica

Source: Carolyn Hall, Costa Rica: Una Interpretacion con Perspectiva Historica (San Jose, C.R.: Editorial Costa Rica, 1984), p. 373

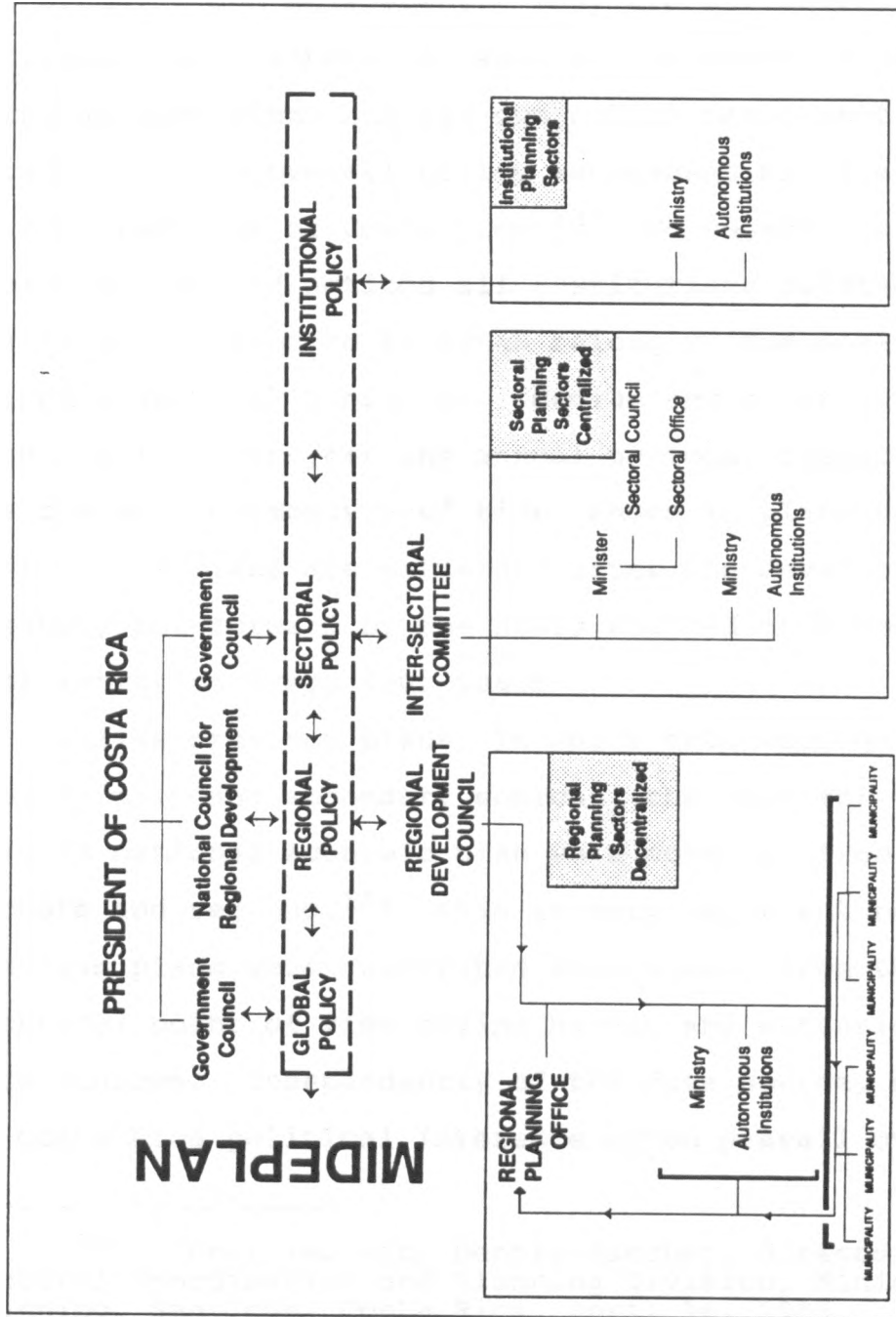


Figure 2.4  
Costa Rica's Economic Planning System

Source: Adapted from, Johnny Meono Segura, "Planificación," Administración Pública (San Jose, C.R.: Editorial Universidad de Costa Rica, 1982), p. 117.

trative Reform Subsystem are the three basic subsystems for planning and management. They are all coordinated by MIDEPLAN. Each subsystem, such as the Health Planning Sectoral Subsystem, has its own policy management level subordinated to overall policy management exercised by the president of Costa Rica.<sup>132</sup> To coordinate health sector policy and actions all institutions related to health in addition to MIDEPLAN belong to the Health Planning Sectoral Subsystem. Medium and short-term planning for four-year and annual periods, respectively, are the most commonly used time ranges in planning.<sup>133</sup> Medium-term plans are patterned after the development strategy put forward by the newly elected government administration every four years.

Unlike previous plans, in which data were gathered from primary and secondary sources, the data for the 1979-82 national economic plan were compiled from the sectors and regions.<sup>134</sup> This is very important because previous plans were elaborated exclusively from the technical point of view paying hardly any attention to data sources. Independently of the data source, however, in Costa Rica political interests often prevail over

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132. Interview with Dennis Sanchez, director of the Sectoral Coordination and Planning Division, Ministry of Planning, San Jose, Costa Rica, April 16, 1985.

133. Johnny Meono Segura, "Planificacion," in Administracion Publica (San Jose, C.R.: Editorial Universidad de Costa Rica, 1982), p. 120.

134. Ibid.

technical recommendations. In Chapter VII we will see that political considerations have also prevailed in the decisions made in the health planning sector in Costa Rica. Conflicts have emerged between MIDEPLAN and the planning offices of other government departments, many of which have not yet adopted MIDEPLAN's regional system.<sup>135</sup> Surprisingly, these plans have been completed and published at the end of each government term in office instead of being drawn up at the outset. It seems that they have been drawn exclusively to comply with international agency stipulations for receiving foreign aid. Therefore, fourteen years and four national development plans later, in 1979 Costa Rica elaborated the first plan to be used to guide government action at the beginning of the government term.

### Improvement in the Health Sector

The effects of the economic and health policies discussed above on health care delivery between 1960 and 1982 can be seen in Table 2.9. Although the number of physicians increased, the number of hospital beds and medical visits decreased. This is the result of reliance by the Rural Health Program and Community Health Program primarily on preventive measures and their use of auxilia-

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<sup>135</sup>. Interview with Jorge Barbosa, government official of the Global Planning Division, Ministry of Planning, San Jose, Costa Rica, April 17, 1985.



ry health workers rather than physicians to provide health care. Table 2.10 compares health care delivery in the seven regions with the highest and lowest indices. The worst indices are in the least developed regions, for example, in Guanacaste and Puntarenas in Costa Rica. Conversely, the best indices are in the capital city of San Jose.<sup>136</sup> The high regional variance in the number of physicians available to the population results from their choosing to be assigned to the regions with the best medical facilities. Smaller variations between regions are observed in the number of hospital beds and medical visits.

Luis Rosero Bixby, a renowned Costa Rican demographer, argues that in addition to the implementation of health programs during the 1970s, the use of the diphtheria, pertussis, and tetanus (DPT) vaccine and a decrease in fertility helped cause the spectacular reduction in infant mortality that took place in the 1970s.<sup>137</sup> Table 2.11 shows a steady decrease in general and infant mortality rates between 1930 and 1982, the latter dropping rapidly after 1970. It also illustrates an increase in life expectancy throughout this time period. Table 2.12 shows regional variances in infant mortality rates between 1979 and 1982. Except for 1980, when a slight increase in

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<sup>136</sup>. Carmelo Mesa-Lago, "Alternative Strategies to the Social Security Crisis," p. 350.

<sup>137</sup>. Luis Rosero Bixby, "Las Politicas Socioeconomicas y su Efecto en el Descenso de la Mortalidad y Fecundidad en Costa Rica," Mortalidad y Fecundidad en Costa Rica, p. 57.

the regional variance is displayed, relatively small differences between regions can be observed.

Table 2.13 displays mortality by cause between 1960 and 1982. There have been dramatic decreases in communicable diseases.

### Conclusions

This chapter has shown that historically both Cuba and Costa Rica have demonstrated concern for social welfare, as evidenced in social and health programs since the nineteenth century. In both cases, the initiation of such programs was triggered by the involvement of the United States. Afterward, successive governments in both settings recognized the importance of expanding the health sector. Thus they have been politically committed to improving the nation's health status. Most important, the multiple economic policies and planning strategies used since the 1960s and the outcomes of these policies seem not to have had a decisive influence on the nations' commitments to the improvement of health status.

Table 2.9

Health Care Delivery in Costa Rica [a],  
1960-1982

Years	Physicians per 10,000 inhabitants	Hospital Beds per 1,000 inhabitants	Medical Visits per capita
1960	3.7	4.5	---
1970	5.1	4.0	4.9
1980	8.9	3.0	3.4
1982	10.0[b]	3.1	3.8

[a] excludes private facilities.

[b] 1983

Sources: Juan Jaramillo Antillon, Los Problemas de la Salud en Costa Rica (San Jose, C.R.: O.P.S., 1984); Mesa-Lago, "Alternative Strategies to the Social Security Crisis: Socialist, Market, and Mixed Approaches," Also, Luis Rosero-Bixby, "Determinantes del Descenso de la Mortalidad Infantil en Costa Rica," Demografia y Epidemiologia en Costa Rica, 1985, pp. 9-36.

Table 2.10

Regional Disparities[a] for Health Care Delivery  
in Costa Rica, 1979

Indicators [b]	Costa Rica (1979)
<hr/>	
Physicians (x 10,000 inh.)	
Range	1.9-12.4
Interval	10.5
Hospital Beds (x 1,000 inh.)	
Range	0.5-5.7
Interval	5.2
Medical Visits (per capita)	
Range	1.8-3.0
Interval	1.2

[a] Comparison between the two provinces with the lowest and highest indices for health care delivery.

[b] Seven provinces. Includes only facilities of the CCSS.

Source: Mesa-Lago, "Alternative Strategies to the Social Security Crisis: Socialist, Market, and Mixed Approaches," p. 352.

Table 2.11

Evolution of Health Indices in Costa Rica  
1930-1982

Years	<u>Mortality Rates</u>		Life Expectancy
	General (per 1,000)	Infant[a]	
1930	23.0	172.0	42.2
1940	18.0	137.0	46.9
1950	12.0	95.0	55.6
1960	10.0	80.0	62.6
1970	6.6	61.5	65.4
1980	4.1	21.0	72.6
1981	3.9	18.1	71.8
1982	3.9	18.8	73.7

Sources: Luis Rosero-Bixby, "Determinantes del Descenso de la Mortalidad Infantil en Costa Rica;" Antillon, Los Problemas de Salud en Costa Rica; Edgar Mohs, La Salud en Costa Rica (San Jose, C.R.: EUNED, 1983).

Table 2.12

Regional Variations[a] for Infant Mortality Rates  
in Costa Rica, 1979-1982

Years	Range	Interval
1979	22.8 - 26.9	4.1
1980	15.8 - 24.8	9.0
1981	14.9 - 20.8	5.9
1982	16.5 - 19.9	3.4

[a] Comparison between the regions with the lowest and highest infant mortality rates.

Source: Juan Jaramillo Antillon, Los Problemas de Salud en Costa Rica (San Jose, C.R.: O.P.S., 1984).

Table 2.13

Mortality by Cause in Costa Rica, 1960-1980  
(per 100,000 inhabitants)

Change	1960	1965	1970	1975	1980	%
Heart Disease	133.0	134.0	141.0	117.0	104.0	
Malignant Tumors	94.0	94.0	78.0	77.0	70.0	
<b>SUBTOTAL:</b>	227.0	228.0	219.0	194.0	174.0	-23%
Infectious and Parasitic	21.0	18.0	11.0	3.0	1.0	
Perinatal	88.0	114.0	77.0	56.0	44.0	
Influenza	108.0	99.0	85.0	42.0	26.0	
<b>SUBTOTAL:</b>	217.0	231.0	173.0	101.0	71.0	-67%
Accidents	n/a	n/a	4.4	n/a	4.1	

Sources: Rosero-Bixby, "Las Politicas Socioeconomicas y su Efecto en el Descenso de la Mortalidad y Fecundidad en Costa Rica," p. 53. Jaramillo Antillon, Los Problemas de Salud en Costa Rica, p. 165-166.

## CHAPTER III

### THE PROBLEM OF EVALUATING PRIMARY HEALTH CARE

Primary Health Care (PHC) is not a new concept. It evolved gradually from the reevaluation of existing approaches and the implementation of new programs and health strategies.<sup>1</sup> The PHC strategy advocated by the World Health Organization (WHO), however, implies a change in emphasis, reordering priorities to include all levels and sectors concerned with the promotion of health. Much practical experience in delivering PHC exists, both in countries that have reoriented their health systems as part of a more general transformation of their socioeconomic systems and in countries that have implemented innovative health projects.<sup>2</sup> Such experiences suggest that there is no one best pattern of PHC, and we observe a variety of organizational and staffing arrangements in less developed countries. Yet certain features are required. Although the effectiveness of PHC in different

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<sup>1</sup>. UNICEF/WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care, p. 7.

<sup>2</sup>. Examples of PHC experience emerge from innovations in the organization of health activities on a national scale in countries such as the People's Republic of China; from more localized health care projects which have incorporated community participation and emphasized the importance of wider socioeconomic factors for the community's health; and from the earlier concept of basic health services which emphasized the delivery of preventive and curative services to all the population. See *Ibid.*, p. 5.



settings should ultimately be measured by its influence on health status, it is appropriate and simpler to first determine whether PHC essential features have been put in place. Researchers concerned with the actual delivery of PHC must pay attention to what PHC really means, how it can be planned, and how its delivery can be evaluated.<sup>3</sup> This chapter is divided into two sections, the first on WHO guidelines, the second on the standards by which PHC will be defined for purposes of this study.

#### World Health Organization Guidelines for the Support of PHC

The WHO emphasizes the use of certain guidelines to support its PHC strategy. These guidelines include political commitment to social and economic justice through an equitable provision of health care and adequate financing for PHC, development of intersectoral approaches to health planning, and an integrated approach to health care within the health service. The WHO also promotes an improved balance between "top-down" planning, organization, and decision making, and decentralization and popular participation in health, economic, and political

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<sup>3</sup>. Barbara Starfield, "Measuring the Uniqueness of Primary Care," Journal of Ambulatory Care Management, August 1979, p. 91.

institutions that affect people's lives.<sup>4</sup> The implementation of these guidelines is contingent on various factors, including (1) coordination of economic and health planning, (2) extension of coverage through regionalization of health services, (3) community participation, (4) research and development of appropriate technologies for PHC, (5) manpower training and utilization, (6) availability of essential inputs and equipment, and (7) international cooperation.<sup>5</sup>

Instead of analyzing each one of these elements as it occurs in Cuba and Costa Rica, this study compares each country's efforts to promote PHC through (1) coordination of health and development planning, (2) regionalization of health services, and (3) community participation in health care. The author's selection of these comparative factors is based primarily upon the feasibility of data collection in each country and the necessity to limit the scope of the

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4. UNICEF/WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care (Geneva: WHO, 1981), p. 6; Bogdan M. Kleczkowski, Ray H. Elling, and Duane L. Smith, "Health System Support for Primary Health Care," Public Health Papers, No. 80 (Geneva: WHO, 1984), pp. 7-10.

5. Pan American Health Organization, Health for All by the Year 2,000: STRATEGIES, Official Document No. 173 (Washington, D.C.: PAHO, 1980), pp. 104-5; World Health Organization, Global Strategy for Health for All by the Year 2000, "Health for All" Series No. 3 (Geneva: WHO, 1981), pp. 40-53.

study. The importance of these three comparative factors for the implementation of PHC is made evident in the theoretical background discussed below.

### Economic Planning, Health Planning, and PHC

In 1967, the WHO, through its Expert Committee on National Health Planning in Developing Countries, pointed out that national health planning should be an integral part of general socioeconomic planning.<sup>6</sup> Today, nineteen years later, health planning in most less developed countries is performed in isolation within ministries of health with few or no links to development planning.<sup>7</sup> In addition, medical professionals are frequently involved, focusing primarily on curative health service programming.<sup>8</sup>

The issues affecting health are multisectoral in nature and could well be discussed by an array of

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6. HE. Hilleboe, A. Barkhuus, and WC. Thomas, "Approaches to National Health Planning," Public Health Papers, No. 46 (Geneva: WHO, 1972), p. 9. See also Kerr L. White et al., Health Services: Concepts and Information for National Planning and Management (Geneva: WHO, 1977), p. 6.

7. Mark Wheeler, "Health Sector Planning and National Development Planning" in Kenneth Lee and Anne Mills, eds., The Economics of Health in Developing Countries (Oxford: Oxford University Press, 1985), p. 190. See also World Health Organization, "Interrelationships between Health Programmes and Socio-Economic Development," Public Health Papers, No. 49 (Geneva: WHO, 1973), p. 28.

8. UNICEF/WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care, p. 25.

ministries and departments. Thus a political forum to set priorities and provide guidance for intersectoral coordination is required to develop a comprehensive health system based on PHC. This forum must have the authority to support the process from policy formulation to implementation.<sup>9</sup>

Wheeler argues that central planning authorities in less developed countries and in many developed countries (DCs) are to blame for not including in their planning schemes the acknowledged interaction between the health sector and other sectors.<sup>10</sup> This is not surprising because most socioeconomic planning institutions do not provide mechanisms for sectoral coordination. In fact, the arbitrary manner in which resource allocations for health are made illustrates how rarely these relationships are recognized by national economic planners. For example, Victor Rodwin documents the failure to link health planning and financing in France, Quebec, England, and the United States.<sup>11</sup> A joint UNICEF/WHO study on PHC

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<sup>9</sup>. Ibid. p. 31.

<sup>10</sup>. Wheeler, "Health Sector Planning and National Development Planning," p. 190.

<sup>11</sup>. Victor G. Rodwin, The Health Planning Predicament: France, Quebec, England and the United States (Berkeley: University of California Press, 1984), pp. 218-20.

showed that mechanisms for resource allocations among most countries in the study were rudimentary or nonexistent.<sup>12</sup>

In such settings, the isolated exercise of health planning is generally based on mortality and morbidity statistics, to which data on physician and hospital use are sometimes added. As a result, the recognition that measures of health and health care needs of the population must be included in health planning is limited.<sup>13</sup> Most important, nearly all resources are committed to existing facilities, which in turn are mainly curative and concentrated in urban areas. Under such constraints, it is difficult to eliminate wasteful services or modify them to a large extent.<sup>14</sup>

Health planning in LDCs is often motivated by the desire to attract foreign grants and loans. As a result, planning ministries and health ministries elaborate plans hastily with negative results.<sup>15</sup> In this setting, health planning methodologies have been developed to seek

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12. The countries included in the study were Burma, Costa Rica, Democratic Yemen, Finland, Mali, Mozambique, and Papua New Guinea. Only Finland and Papua New Guinea showed some positive achievements in linking development planning, health planning, and financing. See UNICEF/WHO Joint Committee on Health Policy, National-Decision Making for Primary Health Care, pp. 26-27.

13. Kerr L. White et al., Health Services, p. 16.

14. Hilleboe, Barkhuus, and Thomas, "Approaches to National Health Planning," pp. 16-17.

15. Ibid., p. 18.

efficiency and equity in resource allocations and to establish criteria to aid in the decision-making process.<sup>16</sup>

The two most common health planning methodologies used in LDCs are (1) pragmatic or empirical planning, and (2) systematic planning. Pragmatic or empirical planning is based on the experience and intuitive skill of the planner or planners. It is characterized by a lack of analytical techniques and by limited specification of the data that should be gathered and used for planning.<sup>17</sup> Conversely, systematic planning is characterized by the use of cost-effectiveness to select health interventions.

According to Waterston and Wheeler, within the pragmatic or empirical tradition three variations can be found: (1) project planning; (2) integrated health services planning; and (3) comprehensive sectoral planning.<sup>18</sup> The plans elaborated using project planning are characterized by an incoherent service structure, few linkages between projects, and few clear criteria for project selection. Moreover, epidemiological data are absent and plans deal exclusively with government health services excluding other health services and programs.<sup>19</sup>

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<sup>16</sup>. Wheeler, "Health Sector Planning and National Development Planning," p. 206.

<sup>17</sup>. Hilleboe, Barkhuus, and Thomas, "Approaches to National Health Planning," p. 13.. See also, Wheeler, "Health Sector Planning," p. 201.

<sup>18</sup>. A. Waterston, Development Planning (Baltimore: Johns Hopkins Press, 1965), p. 101.

<sup>19</sup>. Wheeler, "Health Sector Planning," pp. 201-202.

Conversely, integrated health services planning promotes the development of a coherent structure of services, includes nongovernment providers, and takes into account the epidemiological profile, as well as total availability of resources over time. Equally, resource allocation decisions are taken while the ultimate structure of services is being designed. The crucial difference between project planning and integrated health services planning is that in the latter decisions are taken simultaneously instead of serially and it promotes complementing projects. The predominant similarity is that the main link between national economic planning and health planning is the budgetary limit set by the government on capital and recurrent spending.<sup>20</sup> Comprehensive sectoral planning is a step forward in the evolutionary path of planning efforts. It recognizes the multiple determinants of health status and the need for action in many sectors besides those traditionally included in the health area. Thus the range of data required is greater and includes not only epidemiological and operational statistics but also economic and social data. The scope of policy interventions includes other areas in addition to the direct provision of health services, such as water supply, industrial safety, and food subsidies. Most important, the planning process is interdisciplinary and is carried out by representatives of the health sector serving on

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<sup>20</sup>. Ibid., p. 203.

interdepartmental committees.<sup>21</sup> Because of its wider scope, comprehensive sectoral planning may not be possible for some time in most LDCs.<sup>22</sup>

Pragmatic planning is flexible and can adapt easily to existing political, social, and economic conditions. Its main drawbacks are its tendencies to yield to current forces and to make decisions without adequate information and analysis.<sup>23</sup>

The health planning literature documents three cases of systematic or formal methodology use at the national level: (1) health planning in the USSR; (2) the PAHO-CENDES method; and (3) Country Health programming. The use of cost-effective analysis to choose health interventions is a common feature of systematic methodologies, but, none of these methodologies makes the slightest effort to explain how resource constraints affect the decision process. For instance, health planning in the USSR emphasizes the technical aspects of plan elaboration. By and large, health services are planned in direct response to research dealing with morbidity, hospitalization rates, outpatient visits, and polyclinic care using techniques evaluated through operations research. Research results are used to calculate design standards for curative and prevent-

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<sup>21</sup>. Ibid., pp. 203-04.

<sup>22</sup>. Hilleboe, Barkhuus, and Thomas, "Approaches to National Health Planning," p. 18.

<sup>23</sup>. Ibid., p. 22.



ive care and to create a balance between the subsectors of the health plan and the national economic plan.<sup>24</sup> In calculating the design standards, the cost of a particular project is balanced against the practical effects expected through cost-benefit analysis.<sup>25</sup>

The PAHO-CENDES method was elaborated by the Pan American Health Organization in collaboration with the Center for Development Studies (CENDES) of the Central University of Venezuela.<sup>26</sup> It recognizes limited resources for the health sector and uses cost-benefit analysis for resource allocation. The only benefit used as a criterion for resource allocation, however, is mortality reduction requiring that each death be attributed to one single disease, instead of recognizing the multicausality of mortality. In this manner, it neglects morbidity and disability reduction.<sup>27</sup> The main drawback is that most health programs produce diverse effects; hence it is difficult to allocate resources to single diseases as opposed to assigning them to facilities that attack multiple ailments. Despite the awareness that social and political factors are of crucial importance for

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24. ID. Bogatyrev and MP. Rojzman, "Public Health Planning in the USSR," in Hilleboe, Barkhuus, and Thomas, Public Health Papers, No. 46, p. 43.

25. GA. Popov, Principles of Health Planning in the USSR (Geneva: WHO, 1971), p. 22.

26. Hilleboe, Barkhuus, and Thomas, "Approaches to National Health Planning," p. 52.

27. Ibid., p. 67.

the success of health planning, the designers of the PAHO-CENDES method have not developed criteria to analyze them.

To eliminate the inadequacies of previous health planning methodologies, the most recent methodology put forward by the WHO is Country Health programming (CHP). CHP does not use measures of mortality reduction but of "problem reduction" and includes political and administrative considerations. The methodology consists of three stages: first, formulation of general health policies, strategies, and plans of action; second, broad programming, in which long-term strategic plans are developed and medium-term budgetary implications of strategies are calculated; and third, detailed formulation of programs. The following WHO statement illustrates how CHP is a step forward in health planning methodology:

The matching of technical actions and resource specifications with timid targets of accomplishment permits the formulation of annual budgets so as to convert indicator allocations into firm approvals of program funding.<sup>28</sup>

By and large, systematic methodologies for health planning have been developed under the auspices of the WHO and by the oldest socialist state, the USSR. Neither has developed sensitive techniques for analyzing social and political factors. The statements and resolutions made public by the WHO must accommodate the positions of 150 governments from the entire political spectrum. The USSR does not regard social and political factors to be

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<sup>28</sup>. World Health Organization, Applying Health Country Programming (Geneva: WHO, 1979), p. 79.

important in the health planning process of a socialist country. The Soviet view of socialism as superior to any other economic system, coupled with the elimination of the profit motive from the health sector, leads them to believe that analyzing social and political factors is unnecessary. Judith Pallot and Denis JB. Shaw contend that in the Soviet Union interest groups are different from those existent in a pluralist society. Any political constraints to a particular health plan are considered within the structure of political power and not made public.<sup>29</sup>

Until now, most developing countries have used pragmatic or empirical health planning; very few have used formal, systematic methodologies. The health planning literature generally assumes that mixed economies tend to make use of pragmatic health planning and that centrally planned economies make use of systematic methodologies.<sup>30</sup>

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<sup>29</sup>. Pallot and Shaw argue that interest groups in Soviet society fall into two basic categories: those that are issue-oriented and those that are institutionally or occupationally oriented. The extent to which any group can in fact hope to influence an outcome varies. For more information, see Judith Pallot and Denis JB. Shaw, Planning in the Soviet Union (Athens: The University of Georgia Press, 1981), p. 31.

<sup>30</sup>. For examples see Milton I. Roemer, National Strategies for Health Care Organization: A World Overview (Ann Arbor: Health Administration Press, 1985), pp. 391-400. See also Bogdan M. Kleczkowski et al., "Health System Support for Primary Health Care: A Study Based on the Technical Discussions Held during the Thirty-Fourth World Health Assembly, 1981," Public Health Papers, No. 80 (Geneva: WHO, 1984), pp. 28-30.

Yet Cuba and Costa Rica do not strictly fall into these categories. Until very recently, Cuba adhered to empirical health planning. Since the 1970s, Costa Rica has emphasized the use of a systematic methodology in health planning despite the constraints to its effective implementation and the concomitant use of empirical health planning.

Although most health planning methodologies have been elaborated without connection to national development planning, they do have some points of convergence. For instance, integrated systems of project appraisal have emerged in an effort to relate the selection of individual projects to the goals of national development planning. Equally, issues dealing with cost-effectiveness are the motivation for systems of project appraisal and for health planning methodologies.<sup>31</sup> In this connection, Wheeler contends:

At present, the state of the art of development planning and development models hardly permits a judgement on the overall gain in welfare that may result from a reallocation of resources in favor of the health sector ... it is possible that the best return on the investment in health planning endeavour over the next few years will be found in intrasectoral initiatives, to refine and improve health planning methodologies, and, particularly to make them more sensitive to

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<sup>31</sup>. Wheeler, "Health Sector Planning," p. 206. See also, Pn A. Yotopoulos and Jeffrey B. Nugent, Economics of Development : Empirical Investigations (New York: Harper & Row, 1976), pp. 369-92.

cost, efficiency, and effectiveness considerations.<sup>32</sup>

Thus one cannot definitely assure that systematic planning is superior to pragmatic planning. Despite the quasi-scientific character of systematic methodologies, they lack criteria to analyze social and political factors. These factors are particularly important in the health planning process, not only for the sake of the plan's quality but also because an in-depth understanding of their nature will influence the level of political support for implementing the plan.

Whatever methodology is used, traditionally the health planning process begins by identifying priority health problems. In the context of the resource situation, health care activities are programmed. Frequently the costs of all programs exceed the available resources, either during planning or implementation.

Health planning for PHC requires analysis of the existing allocation of health care resources disaggregated by public and private sectors, geographical area (urban/rural), and level of care. Afterward, the results of such analysis can be used to (1) assign resources to PHC as it relates to secondary and tertiary care, (2) distribute resources to reduce inequalities in health

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<sup>32</sup>. Wheeler, "Health Sector Planning," pp. 206-07. For an example of an effort to quantify the relationship between the health sector and other sectors through a simulation model, see B. Christian et al., "Health and Socio-Economic Development: An Intersectoral Model," Social Science and Medicine 11 (1977): 63-69.

status and health care expenditures per capita among regions, and (3) program health care activities preferably on a decentralized basis. To assure that enough resources will be available for the implementation of PHC, health activities must be planned concurrently with the provision of resources.<sup>33</sup> Moreover, to analyze and modify the existing allocation of resources for PHC by geographical area and by level of care, regionalization of health services is required.

### Regionalization of Health Services

A regionalized health care system is a prerequisite for attaining the essential features of PHC.<sup>34</sup> Regionalization not only increases the cost-effectiveness of resources, but it also promotes access to the most appropriate level of services according to health care needs.

Regionalization means dividing a country into several regions or coalescing several local units into sets of larger regions.<sup>35</sup> In the health field, however, regionalization also implies an organized scheme of flows

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<sup>33</sup>. Victor G. Rodwin, Health Planning Predicament, pp. 234-35.

<sup>34</sup>. Barbara Starfield, "Measuring the Attainment of Primary Care," Journal of Medical Education 54 (1979): p. 367.

<sup>35</sup>. TS. Bodenheimer, "Regional Medical Programs: No Road to Regionalization," Medical Care Review 26 (1969): pp. 1125-26.

and linkages between regions. Regionalization creates new linkages between institutions in a region and helps relate the health delivery system to the maintenance and improvement of health.<sup>36</sup> The formation of these linkages will depend on such intervening conditions as (1) the conditions and ways of life of the people who are pathogenic; (2) the sophistication of the users and providers of services regarding curative and preventive care; (3) satisfaction with care on the part of providers and users; (4) the patient's timely entry into care (seldom or too soon); and (5) the logic of the care process once a person has entered the health system.<sup>37</sup>

Three interrelated features of the regionalization of health services stand out: a network of regional services, health services areas or districts, and regional planning. Basic to the concept of integrated patient care services is the development of a network of health care facilities, each with a specific capacity ranging from primary services at the periphery to highly specialized services at the core or base facility. Between these extremes are intermediate care facilities and activities that provide varying levels of service according to the requirements of the population. A regional framework of integrated services consisting of various health service areas or

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<sup>36</sup>. Ibid.

<sup>37</sup>. RH. Elling, "Regionalization of Health Services: Sociological Blocks to the Realization of an Ideal" in SR. Ingman and AE. Thomas, eds., Topias and Utopias in Health (The Hague: Mouton, 1975), p. 178.

districts is a prerequisite for planning and delivery of health care at the regional level.<sup>38</sup>

Regarding the conditions that promote the implementation of a regionalized health care system, a former officer of the PAHO suggested,

It is, of course easier to bring about regionalization of the health services in those countries which have a planned economy and a decentralized economic and social development administration. It is also very helpful when there exists at the regional level, a political and administrative body with executive and coordinating authority over the regional services, not only in the health, but also in the educational, welfare, and other fields. Even when these ideal conditions do not exist, it is possible for countries to establish a regionalized health service provided a firm political decision is taken and is backed by legislation. Measures to complement the foregoing will be the adoption of uniform administrative and information methods and statistical nomenclature and the establishment of joint training programs for the directing and executive personnel of the participating institutions.<sup>39</sup>

To attain success, regional systems may need to be reorganized. Moreover, the local economic, social, political, geographic, and epidemiological circumstances must be considered. Cuba and Costa Rica have been successful in establishing structures for regionalized health services, but both countries have encountered many problems in establishing regionalization because of strong centraliz-

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<sup>38</sup>. D.A. Pearson, "The Concept of Regionalized Personal Health Services in the United States, 1920-1955" in E.W. Saward (ed.), The Regionalization of Personal Health Services (New York: PRODIST, 1975), p. 43.

<sup>39</sup>. Alfredo Leonardo Bravo, "Regional Planning of Health Facilities: From the Viewpoint of the Health Planner," WHO Offset Publication 37 (1977) 14.



ing tendencies. Such centralization has also affected the ability to establish genuine community participation in PHC.

### Community Participation and PHC

Community participation is one of the main strengths of the PHC strategy. It seeks to increase personal and social responsibility for health, and contributes to development.<sup>40</sup> Although community participation has gained much popularity, it has not gained clarity. There are many reasons for involving the community in health activities, from increasing existing health care resources to providing the conditions necessary for restructuring the present health care delivery system.<sup>41</sup> Therefore, differences of opinion exist about how the public can participate in health care activities.

Susan B. Rifkin has described three approaches presently used in community participation relevant to the implementation of PHC in developing countries: (1) the public health approach, which justifies public participation to assist in the eradication or control of

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<sup>40</sup>. Bogdan M. Kleczkowski et al., "Health System Support for Primary Health Care," p. 33.

<sup>41</sup>. Susan B. Rifkin, "The Role of the Public in the Planning, Management and Evaluation of Health Activities and Programmes, Including Self-Care," Social Science and Medicine 15A (1981): 377; GM. Hochbaum, "Consumer Participation in Health Planning: Toward Conceptual Participation," American Journal of Public Health 59 no.9 (1969): 1699.

communicable diseases; (2) the health planning approach, which uses community participation to create additional health resources such as manpower, money, and materials and to gain public support for better use and development of health services; and (3) the community development approach, which contends that public participation is necessary to correct the imbalance in the distribution of health resources, and to have the poor and underprivileged become active in decisions that affect their lives.<sup>42</sup>

Different countries have different structures of authority and degrees of community involvement in the control and distribution of resources. These structures influence whether genuine community participation can be realized in a particular society.<sup>43</sup> Hence, participation will vary according to sociopolitical situations. For example, where communities of rural poor are made up of smallholders and landless workers and large landholders monopolize land (the main productive resource), power tends to belong to the rich. In this setting, community health programs are developed to mitigate the potentially explosive effects of great poverty and great inequality. Here the health sector can be heavily weighted toward

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<sup>42</sup>. Rifkin also analyzes the self-care approach which is marginally relevant to the community participation experience in LDCs. For more information see Rifkin, "Role of the Public," p. 377.

<sup>43</sup>. Kleczkowski et al., "Health System Support for Primary Health Care," p. 33.

urban curative care, absorbing most of the country's health care resources.<sup>44</sup>

A second situation is when rural communities are relatively homogeneous and family resources do not differ greatly. Although urban and health elites are favored, policies established by the government in power express concern for rural development and improvement of the living standards of the rural majority. Local initiatives can be stimulated by nongovernment organizations working in the communities and transferred to higher authorities. In this setting, community involvement in PHC may not only contribute to greater self-reliance but also help the rural poor to understand the fundamental causes of underdevelopment.<sup>45</sup>

Finally, there is the situation of community participation in socialist developing countries. Although a central ideological tenet of socialism is that development should benefit the peasants and workers, new urban elites with privileges based on party membership and/or government office usually emerge in such countries. These privileges are also present in health care, and strong one-party systems represent the sole legitimate channel of political expression. Moreover, public questioning of policies is not accepted. Various mobilization and participatory structures linked to

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<sup>44</sup>. UNICEF/WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care, p. 34.

<sup>45</sup>. Ibid., p. 35.

the political structure emerge to play an important part in health campaigns. Yet such structures of mobilization usually inhibit questioning of health policies established by those considered to be "health experts." The main purpose of the participatory structures is to help implement health campaigns designed at the central level. As a result, they limit the potential contribution of community involvement.<sup>46</sup>

Because economic and health planning, regionalization of health services, and community participation are complex problems, the development of a strategy for PHC is not easy. Further, limitations are rapid population growth and increased urban concentration. In addition, most development strategies tend to increase inequities between urban and rural areas and among different groups of the population. Finally, the lack of cooperation among members of health teams and lack of trained personnel to promote health education also hinder the implementation of PHC.

### The World Health Organization Approach

Although there is much practical experience in implementation of PHC, development of the PHC strategy promoted by the WHO has been hampered by a lack of specificity. The WHO provides general, loosely defined

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<sup>46</sup>. Ibid., p. 37.

guidelines for implementation and evaluation of that can be used by the whole array of countries belonging to the organization.<sup>47</sup> The minimal list of global indicators defined by the WHO to be used by all countries to monitor their progress toward "health for all" is given in Appendix A. This list includes the following indicators directly related to PHC delivery,

safe water in the home or within 15 minutes' walking distance, and adequate sanitary facilities in the home or immediate vicinity; ... immunization against diphtheria, tetanus, whoopingcough, measles, poliomyelitis, and tuberculosis; ... local health care, including availability of at least 20 essential drugs, within one hour's walk or travel; ... trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age.<sup>48</sup>

The nonspecific nature of such indicators is noteworthy. The WHO argues that countries should choose evaluative indicators that are appropriate to their particular social, economic, and health situations. Moreover, WHO contends that because socioeconomic and health situations are evolutionary, indicators should also be evolutionary.<sup>49</sup> From this point of view its rationale seems justified.

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47. World Health Organization, Health Programme Evaluation: Guiding Principles for Its Application in the Managerial Process for National Health Development (Geneva: WHO, 1981), pp. 26-43. See also World Health Organization, Development of Indicators for Monitoring Progress towards Health for All by the Year 2000 (Geneva: WHO, 1981), pp. 28-32.

48. World Health Organization, Global Strategy for Health for All by the Year 2,000, p. 76.

49. Ibid. p. 73.

Yet such guidelines are not very useful to characterize the essential features of PHC at the local level in different settings although they provide a general framework for countries to follow.

### Descriptive Criteria for PHC

Given the inadequacy of the WHO guidelines in delineating the essential features of PHC, the descriptive criteria developed by Stephen and Starfield will be used for that purpose in this study. Within the health planning literature these are the only authors who develop criteria to evaluate the essential features of PHC delivery, namely, first-contact care, coordination of care, comprehensiveness, and longitudinality.<sup>50</sup> Such features emerge from the interaction between structure, process, and outcome of a health care system. Research that deals with provision of health services, specifically PHC, should examine the interaction between the structure, process, and outcome of a health care system.<sup>51</sup> This study attempts to do that.

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<sup>50</sup>. See Barbara Starfield, "Measuring the Uniqueness of Primary Care," Jou.rnal of Ambulatory Care Management, August 1979, p. 91; Barbara Starfield, "Health Services Research: A Working Model," New England Journal of Medicine 289, no. 3, (July 19, 1973); Barbara Starfield, "Measuring the Attainment of Primary Care," Stephen, "Primary Medical Care and the Future of the Medical Profession."

<sup>51</sup>. Barbara Starfield, "Measuring the Attainment of Primary Care," pp. 365-366.

Structure includes the resources which enable the health unit at the primary level to provide services--the types and numbers of health workers, facilities and equipment, range of services offered, type of organization (government/private sector), arrangements for continuity of care, accessibility of care, mode of financing, and population coverage.

Process deals with how the system functions in reality. Two main aspects contribute to the process component--one is contributed by the providers and the other by those whom the health unit serves. The providers are concerned with recognizing problems, formulating diagnoses, management, and reassessment to determine achievement of management goals. The receivers of care are involved in use of services, acceptance of and satisfaction with the system, understanding the way services are provided, and participation in planning and implementation of health activities.

To determine the effectiveness of the PHC system, inferences on its likely outcomes on health, patients' satisfaction with health, and functional ability are made.

Each of the four descriptive criteria for PHC, first-contact care, coordination, comprehensiveness, and longitudinality, can be assessed by examining a structural element and a process element.<sup>52</sup> This is done as follows:

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<sup>52</sup>. WJ. Stephen, "Primary Medical Care," p. 320.

To evaluate first-contact care, accessibility to and use of services for each new problem that prompts individuals to seek health care must be determined. Unless care is accessible and available for long hours, patients will most likely use the emergency room of the local hospital or the services of private medicine. Therefore, accessibility and use patterns are vital in evaluating first-contact care.

Coordination of care requires some form of continuity, either by the physician, by medical records, or both, and of problems which will be easier if the same physician sees the patient on follow-up or if there is a medical record which specify these problems. Continuity of care is valuable both to the physician and to the patient in facilitating communication and establishing empathy.<sup>53</sup>

Another descriptive criterion for PHC is comprehensiveness. This criterion implies not only referrals to the secondary and tertiary levels, but also arrangements for essential supporting services such as home care and other community services. To attain comprehensiveness the PHC units must be able to arrange for the patient to receive all needed health care services, even if some cannot be provided efficiently within the PHC level. Regardless of the range of services offered by the PHC unit, the unit staff must be able to explain clearly to the population served the health

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<sup>53</sup>. Ibid.



services that are available. Aside from providing preventive health services, the PHC facility must be able to deal with symptoms, signs, and diagnosis of illness. Service units must be able to recognize functional, organic, or social problems.<sup>54</sup> The degree of comprehensiveness of services offered will influence whether a patient will skip the PHC level and go directly to the secondary and tertiary levels.

The last descriptive criterion developed by Starfield is longitudinality, the existence of a regular source of care and the use of that source over time. It is of great relevance to the attainment of PHC because the extent to which the PHC can identify its eligible population will influence whether the individuals in that community will obtain care from that unit.

These descriptive criteria--first-contact care, coordination of care, comprehensiveness, and longitudinality--will be used to examine the distinctive features of PHC as they occur in Cuba and Costa Rica in Chapters V and VI.

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<sup>54</sup>. Starfield, "Measuring the Attainment of Primary Care," p. 367.

## CHAPTER IV

### DELIVERY OF PRIMARY HEALTH CARE IN CUBA

Most literature on Cuban health care describes the achievements and general characteristics of the health sector, but much of this information does not tell us how the system actually works, and most important, it is never challenged. In most cases, this is the result of lack of data because of the constraints in undertaking research in Cuba. The main goal of this chapter is to discuss the delivery of primary health care in Cuba.

Chapter III argued that the delivery of primary health care must include certain essential features if it is to become the main pillar of the health care system.<sup>1</sup> These essential features include first-contact care, coordination of care, comprehensiveness, and longitudinality. This chapter analyzes whether such features are observed in Cuba. For this purpose, the chapter is divided into two sections. The first section describes the PHC model implemented in Cuba, and the second section discusses the delivery of PHC.

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<sup>1</sup>. WJ. Stephen, "Primary Medical Care," p. 315; Starfield, "Measuring the Attainment of Primary Care," p. 361.

## CUBA'S MODEL

## Community Medicine

The delivery of PHC in Cuba is based on the Community Medicine Model (CMM). This model emphasizes the integration of preventive and curative health activities including social, psychological, and environmental elements. Four basic specialties are offered--internal medicine, pediatrics, obstetrics and gynecology (OBGYN), and dentistry.<sup>2</sup>

Therefore, unlike most LDCs, PHC is delivered by medical personnel. The director of the Cuban Research Institute for Health Development, Dr. Jorge Aldereguia, justifies this strategy as follows:

In Cuba, PHC is offered by medical personnel due to the high priority conceded by the Communist Party and the State to the improvement of the population's health...The use of non-medical personnel and simplified technologies in LDCs to solve their health problems is only valid if it is complemented with the rapid development of medically trained human resources and the creation of a wide network of preventive-curative units.<sup>3</sup>

The Cuban strategy for PHC delivery has been criticized as an extremely expensive and non viable option for LDCs in

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<sup>2</sup>. In Cuba, following the nomenclature used in the USSR and the East European countries, dentistry is referred to as stomatology. See Jose A. Gutierrez Muniz et al., Fundamentacion para un Nuevo Enfoque de la Medicina en la Comunidad (La Habana, Cuba: MINSAP, 1977), p. 29.

<sup>3</sup>. Jorge Aldereguia Valdes-Brito et al., "El Papel del Instituto de Desarrollo de la Salud en la Atencion Primaria," Revista Cubana de Administracion de Salud 10, no. 3 (July-September 1984): 193.

light of human and material constraints. For example, according to Dr. Ignacio Macias Castro, director of the Cuban National Health Promotion Program for the Control of Chronic Diseases,

Whenever World Health Organization officials visit Cuba they tell us that our PHC model for the control of chronic diseases, and otherwise is extremely costly. In fact, even Dr. Halfdan Mahler, general director of the WHO, stated to our commander in chief, Fidel Castro, that our health care system as a whole is too costly and still spends too many resources on tertiary care.<sup>4</sup>

Besides the use of medical personnel for the delivery of PHC, the CMM relies on teamwork. Two types of health teams exist: horizontal primary teams and vertical primary teams.

The horizontal teams consist of the physician, i.e., the generalist or internist, the pediatrician, or the OBGYN; and nursing personnel. When actions dealing with the social environment of the patient are called for, social workers also form part of the team. Each team maintains its own files with the patients' records belonging to its sector. Thus the health team can easily coordinate the flow of health information with the Statistics Office within the PHC unit. As a result,

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4. Interview with Dr. Ignacio Macias Castro, director, National Health Promotion Program for the Control of Chronic Diseases, Salvador Allende Hospital, La Habana, Cuba, July 28, 1983. For more information on the high cost of Cuba's PHC model see, David Werner, "Health Care in Cuba: A Model Service or a Means of Social Control--or Both?" in David Morley et al., Practicing Health for All (Oxford, England: Oxford University Press, 1984), pp. 32-33.

primary data necessary for health programs evaluation are easily accessible.

The vertical primary team is formed by individuals belonging to similar disciplines, such as hygiene workers, statisticians, social workers, and so forth. Coordination between the horizontal and vertical teams occurs when joint actions are required, such as environmental actions, or when epidemiological studies are undertaken.<sup>5</sup>

Ironically, despite the importance of teamwork in the CMM, the members of the health team usually do not work together. By and large, the director of the PHC unit and the chief of the statistics department of such unit have been the ones integrating program activities. This situation reflects the primacy of the Cuban physician within the health care system and his or her unwillingness to share responsibility for patient care responsibilities with other team members.

Another important feature of Cuban PHC, incorporated into the CMM in an attempt to achieve integration between preventive and curative health activities, is called sectorization. The health area served by the PHC unit is divided into sectors according to the age and sex groups living and/or working in the area. The work of the physician/ nurse teams is "sectorized" in the fashion of a geographically bound capitation system. Moreover, they are responsible for the sectors activities related to the

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<sup>5</sup>. Muniz et al., Fundamentacion para un Nuevo Enfoque de la Medicina. p. 31.

patients' health disease process, whether they are diseased or not, including their physical and social environment.<sup>6</sup> The physicians charged with the internal medicine and OBGYN sectors are assigned four thousand adult patients each, and the pediatrician is assigned two thousand patients.<sup>7</sup> For example, a pediatrician/nurse team is responsible for the health promotion of all the children in a specified sector. In most cases, however, the physician charged with the internal medicine sector, is not an internist, but a non specialized or generalist physician because there are not enough medical internists to cover all PHC units on the island.<sup>8</sup>

Another very important feature of the CMM is control or dispensarization<sup>9</sup> which is used in conjunction with sectorization to (1) provide follow-up care to healthy and diseased patients; (2) detect illness at an early stage; (3) keep surveillance of high-risk population groups; (4) supervise the treatment of diseased individuals; and (5) prevent the recurrence of illness. Presently, it has been

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6. Ibid., p. 29.

7. Alberto Cespedes, national director of polyclinics, Ministry of Public Health, "Address: The Polyclinic," in MINSAP/WHO, International Conference Health for All: 25 Years of Cuban Experience, July 3-9, 1983 (La Habana, Cuba).

8. Interview with Dr. Ignacio Macias Castro.

9. The word "dispensarization" is a literal translation of the Spanish word for this concept namely, "dispensarizacion." Since the basic idea behind the concept is maintaining periodic control of high-risk patients the word "control" will be used instead when referring to "dispensarizacion."

implemented at the PHC level only.<sup>10</sup> Once the physician and his or her team have assessed their health sector, they determine which patients should be periodically "controlled" according to risk, and a register of high-risk patients is kept. High-risk patients are those with chronic or acute conditions, such as asthma, diabetes, epilepsy, hypertension, and malnutrition. The average physician/nurse team schedules one afternoon weekly for home visits to evaluate the sector. In the rural areas, however, if too many patients have come in to see the physician, he or she instructs the nurse to do home visiting that day.<sup>11</sup> The home-visiting strategy has not been very successful because the visits are scheduled when people are at work, not in the home. Once the patient is placed under medical "control," three appointments are programmed annually for follow-up treatment. Thus "control" measures the prevalence of acute and chronic diseases among the Cuban population.

A positive outcome of "sectorization" and "control" is that it assures continuity of care. Priority is given to high-risk patients. The primary health team not only keeps the records of the patients belonging to its sector but also card files indicating risk categories. For each

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<sup>10</sup>. Mario Escalona Reguera, "La Dispensarizacion en el Sistema Nacional de Salud," Revista Cubana de Administracion de Salud 10, no. 3, (July/September 1984): 202.

<sup>11</sup>. Interview with Dr. Elio Garrido, National Office of Polyclinics, Ministry of Public Health, La Habana, Cuba, July 20, 1983.

category, the team follows a specific case-review protocol. For example, the OBGYN will routinely request to see the mother of a high birthweight newborn to be certain the mother is not diabetic. Also, hypertensive adults will be examined by the internal medicine team three times a year.

In reality, however, the totality of the Cuban population is not presently under "control" because of the lack of resources and little cooperation from the population. This situation is evident in the following explanation provided by Dr. Ignacio Macias Castro:

Forty percent of the population is not under "control" for chronic diseases. Difficulties arise given that around 50 to 60 percent of the Cuban population does not attend the PHC unit spontaneously. Eighty percent of those who do attend are women. The strategy used to alleviate this situation has been to send out a letter to each citizen urging them to visit the PHC unit. However, only 40 percent respond. A second letter is then sent out and the response rate increases to 55 percent. The rest are sought out by the health team in their homes on Saturday afternoon or Sunday morning. Once the patient is dispensarized [under control] if they do not come in for their appointments they are once again visited in the home or urged to attend the PHC unit by a mass organization representative. Our statistics show that the CMM is available to 80 percent of the total Cuban population.<sup>12</sup>

The PHC physician, then, is responsible not only for those patients who appear at the primary level but also for those who do not.

A strong health education component is incorporated into the CMM. Unlike other Latin American countries,

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<sup>12</sup>. Interview with Dr. Ignacio Macias Castro.



however, where the professionals involved in health education are health educators, in Cuba health educators guide health professionals to do health education.<sup>13</sup> Yet the results obtained in getting people to change health habits and practices through the efforts of these health professionals have not been encouraging.<sup>14</sup> Health education in Cuba consists of constantly encouraging the population to see the physician for even the most minor ailment.<sup>15</sup> By 1983, health education efforts were directed toward health promotion through (1) the reduction of obesity, sedentary lifestyle, and heavy smoking; (2) sex education, as a result of the increase in teenage pregnancies; and (3) accident prevention because accidents are the first cause of death in the 15-49 year age group.<sup>16</sup> To be effective, changes in lifestyle are required.

The previous discussion on the CMM indicates that the PHC physician in Cuba continues to give priority to curative medicine, not fully aware of the multiple actions involved in providing integral health care. This happens despite the one-year clinical training given to medical

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13. Interview with Dr. Rafael Borroto Chao, national director for health education, Ministry of Public Health, La Habana, Cuba, July 13, 1983.

14. Interview with Dr. Carmen Santos, director of the Nutrition Institute, La Habana, Cuba, July 15, 1983.

15. David Werner, "Health Care in Cuba: A Model Service or a Means of Social Control--or Both?" in Morley et al., Practicing Health for All, p. 28.

16. Interview with Dr. Rafael Borroto Chao.

students at the primary level, a policy seldom seen in any other country, developed or underdeveloped. In fact, the hospital and research institute enjoy the highest status within the health sector, disregarding the importance of the social and psychological aspects of health.<sup>17</sup> In the words of Dr. Jose A. Gutierrez Muniz, former minister of Cuba's Ministry of Public Health,

We have been able to transform basic health services following the objectives and principles of a socialist society, but regarding the formation of the physician we have not achieved the same degree of change, maintaining almost unaltered the pattern of the previous economic system which does not correspond with the present requirements of PHC in our society. The hospital continues to be the physicians' main work base; and their main learning tool, the sick individual.<sup>18</sup>

If the Cuban health care sector wants to change the way the Cuban physician and the general population view PHC, it must start by shifting resources from tertiary care. Higher salaries and status for physicians at the primary level and improvement of the quality of services available to the population at that level would definitely improve the status of the PHC physicians in Cuba.

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<sup>17</sup>. Luis Rodriguez Rivera, "La Importancia del Equilibrio Armonico entre el Hospital y la Comunidad en la Formacion del Medico," Revista Cubana de Administracion de Salud 7 (July/September 1981): 200, 204.

<sup>18</sup>. Interview with Dr. Jose A. Gutierrez Muniz, former minister of public health, Research Institute for Health Development, La Habana, Cuba, July 20, 1983.

### The Institutional Structure

Health literature on Cuba often adduces the polyclinic as the basic unit of the Cuban National Health System and the only vehicle for the delivery of PHC.<sup>19</sup> The polyclinic serves only the urban areas, however, whereas the rural hospital and medical post deliver PHC in the rural areas.<sup>20</sup> These three types of health units constitute the first level of health care of the regionalized health care system.

The polyclinic is responsible for all health actions related to the population or the environment in the territorial zone assigned to the unit, including work centers, day care centers, and schools. The average polyclinic serves an area of two square kilometers, although new polyclinics cover one square kilometer.

The polyclinic is managed by a director who must be a physician or dentist and who is appointed by and is directly responsible to the People's Power Municipal Assembly. The polyclinic's director is aided in his or her functions by the Polyclinic Directive Council,

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<sup>19</sup>. See, for example, Paul Harrison, "Cuba's Health Care Revolution," World Health, December 1980, pp. 2-8. See also Ross Danielson, Cuban Medicine (New Brunswick: Transaction Books, 1979); Alberto Cespedes, "Address: The Basic Unit of PHC: Polyclinics in Cuba" in MINSAP/WHO, International Conference "Health for All".

<sup>20</sup>. Interview with Dr. Elio Garrido Alvarez.

consisting of the chiefs of each of the health services.<sup>21</sup> To illustrate the municipal level of the Ministry of Health and the position of the polyclinic within it, see Figure 4.1.

Polyclinics are differentiated by two features: (1) the number of inhabitants they serve; and (2) whether they are teaching or nonteaching, categorized by the number of inhabitants served, there are three types of polyclinics in Cuba. Type One Polyclinics service small communities of seven to ten thousand inhabitants and are available in very few areas of the Island. The most common are Type Two and Type Three Polyclinics. Type Two delivers PHC to populations of ten to twenty thousand inhabitants; Type Three services populations of twenty-five to thirty thousand inhabitants.<sup>22</sup> Dr. Ignacio Macias Castro asserts,

"the difference between teaching and non-teaching polyclinics is enormous. Teaching polyclinics have a higher budget, more resources and more personnel. Also, the personnel have more academic training than those working in a non-teaching polyclinic given their teaching responsibilities."<sup>23</sup>

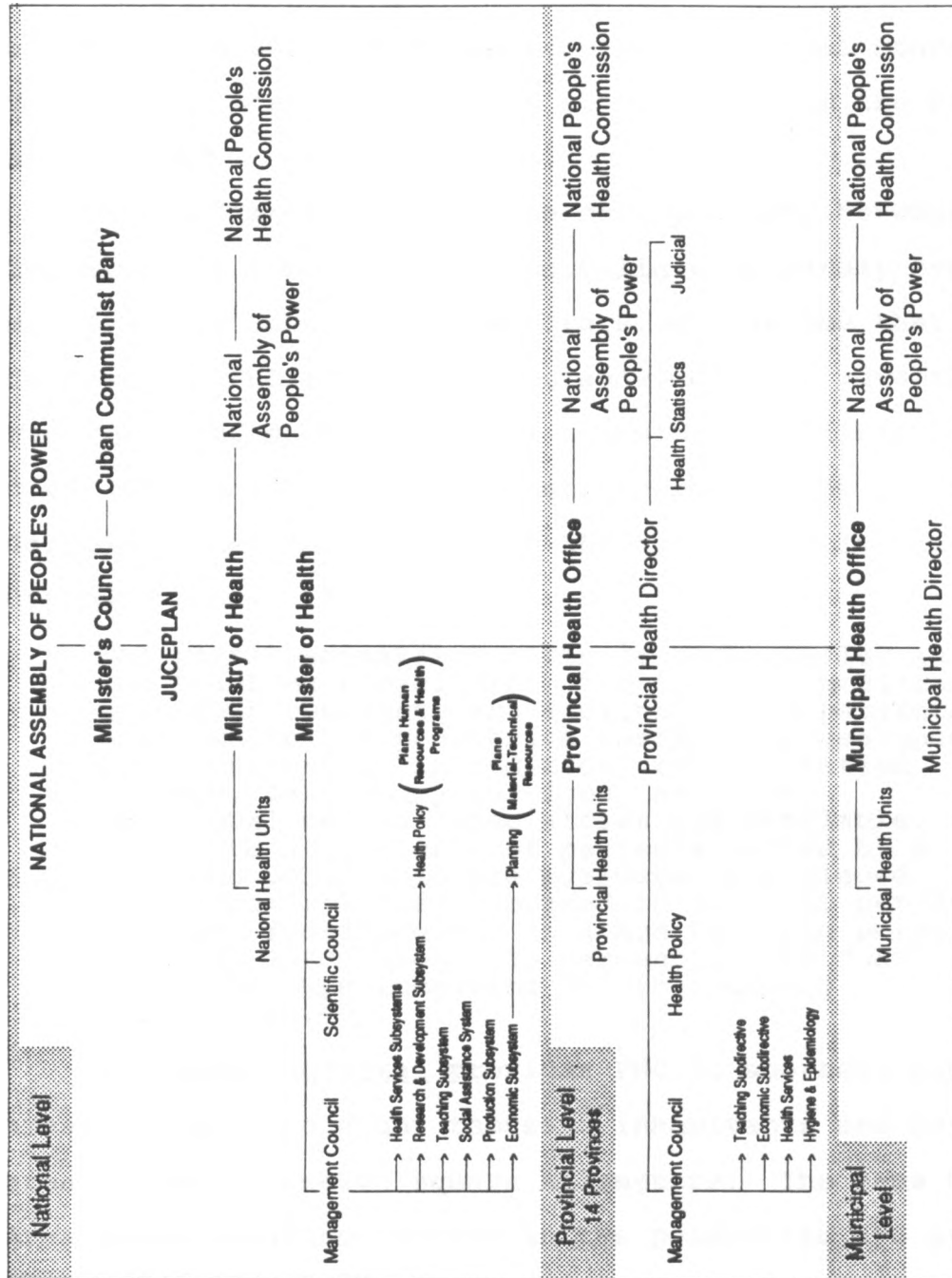
Aside from teaching, the personnel in a teaching polyclinic provide direct health care. Moreover, research projects are undertaken in coordination with the research

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21. Mario Escalona Reguera, Temas de Administracion de Servicios y Programas de Salud Publica (La Habana, Cuba: MINSAP-IDS, 1983), pp. 309-10.

22. Interview with Dr. Elio Garrido Alvarez.

23. Interview with Dr. Ignacio Macias Castro.



**Figure 4.1 National, Provincial and Municipal Level of the Ministry of Health in Cuba**

**Source:** Interview with Dr. Mario Escalona Reguera, Institute for Health Development, La Habana, Cuba, October 26, 1983; Mario Escalona Reguera, Temas de Administración de Servicios y Programas de Salud Pública pp. 118-123 and 240-244.

institutes. Therefore, the chiefs of the internal medicine, OBGYN, and pediatric sections are specialists and teach in the respective provincial medical schools.<sup>24</sup> The medical staff consists of residents in the basic specialties.

The differences in health care delivery between a teaching and a non-teaching polyclinic is hardly ever mentioned by Cuban health scholars, who assume that the delivery of PHC is standard islandwide. The advantages of receiving PHC services from a teaching polyclinic are clear in the following explanation provided by Dr. Elio Garrido, a health official in the National Polyclinics Office,

The physician-patient ratio is much smaller in the teaching polyclinic. The internal medicine and OBGYN residents are assigned 2,000 patients each, while the pediatrics resident is assigned 1,000 patients. In addition, rehabilitation therapy, laboratory services, and nine additional medical specialties are available. Eighty to 90 per cent of patients served by a teaching polyclinic are evaluated and placed under "control," as compared to 40 to 50 percent of those receiving PHC in a non teaching polyclinic. By 1983, around 10 percent of the Cuban population was receiving PHC in teaching polyclinics.<sup>25</sup>

The rural hospital provides PHC to sparsely populated areas of seven to eight thousand inhabitants and serves an area of ten to twelve square kilometers. The same Health Area Basic Programs offered in the polyclinic are provided

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24. A medical school has been built in each of the provinces to reduce the concentration of health services and medical personnel in the Havana area.

25. Interview with Dr. Elio Garrido Alvarez.

rural population are still inadequate.<sup>29</sup> For instance, the distribution of the health institutional network in both provinces did not correspond with population distribution. Population exceeded thirty thousand inhabitants in four of the twelve health areas of the Santiago de Cuba province. The Cuban standard for rural health areas is five to seven thousand inhabitants. As a result, access to health services in the rural areas of these two provinces is limited. Moreover, the study showed that human and material resources in rural health institutions are scant and limit coverage. Thus, efforts to lure specialized medical personnel to rural areas have not been successful and do not satisfy present needs. Finally, the study demonstrated that most of the rural population has not been sectorized or placed under "control," two essential features of PHC in Cuba.

As stated earlier, PHC is also available to the workers in their work center in conjunction with the nearby polyclinic or rural hospital. PHC is also provided within certain production units. To establish medical services in the unit there must be (1) more than five hundred workers employed in the production unit, and (2) a high incidence of job-related accidents in the unit. To increase the quality of health care delivery and knowledge

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<sup>29</sup>. Lorenzo Somarriba Lopez et al., "La Atencion Medica de la Poblacion Rural en las Provincias de Santiago de Cuba y Sancti Spiritus. Ano 1981," Revista Cubana de Administracion de Salud 10, no. 3, (July/September 1984): 230.

in the area of workers' health, the first occupational health polyclinic was established in the Cienfuegos province in 1983. According to Dr. Jorge Mugica Cantelar, a professor and researcher at the Occupational Health Research Institute,

The Cienfuegos Province is of great economic importance, it is the site of multiple chemical industries and a nuclear plant; thus, high risk of workers contamination is prevalent. The occupational health polyclinic provides preemployment checkups and continuous surveillance of the health status of workers. In the Cienfuegos area, there is a high risk of lead contamination.<sup>30</sup>

Most important, the establishment of an occupational health polyclinic has begun a trend to develop Specialty Polyclinics, a totally new concept in PHC delivery for LDCs.

These polyclinics provide specialized medical care for a set of communities and work in close association with the research institutes in health-related research projects.

The research-oriented strategy used in specialty polyclinics is one way to increase the status of the polyclinic and of PHC. It also motivates physicians and other health professionals to work in the primary level.

Not much operative information is available, however, because they have been established very recently.

Regarding the operating cost of a PHC unit, Dr. Elio Garrido, a health official of the National Polyclinics Office, explains,

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<sup>30</sup>. Interview with Dr. Jorge Mugica Cantelar, academic sub-director, Occupational Health Institute, La Habana, Cuba, August 5, 1983.



The average operating cost of a polyclinic or rural hospital is unavailable given that some PHC units offer eight specialties, while others provide only two or three specialties. However, a Type Three Polyclinic is usually allocated an annual average budget of 100,000 pesos. The PHC unit budget is approved by People's Power and the unit Director tries to maintain expenditures within budget, in most instances with little success.<sup>31</sup> The Health Area Basic Programs are financed through budgetary allocations made by the People's Power Provincial Directives. The Cuban government seems reluctant to provide budgetary data, but I believe the information does exist. For example, Dr. Luis Rodriguez Rivera, a Cuban researcher and professor in the Havana Medical School, contends in a published research paper that most health resources are presently spent in the highly specialized tertiary level of care, not in PHC.<sup>32</sup> This underscores that PHC is not the basic pillar of the health system; curative care continues to be the main focus despite efforts to strengthen the primary level. It seems there are conflicting forces among health policy makers in Cuba. In the words of Dr. Jose A. Gutierrez Muniz, former minister

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<sup>31</sup>. Interview with Dr. Elio Garrido Alvarez. One Cuban peso equals \$1.35.

<sup>32</sup>. Luis Rodriguez Rivera, "La Importancia del Equilibrio Armonico entre el Hospital y la Comunidad en la Formacion del Medico," p. 204. For more information on the emphasis given to tertiary specialized care, see GRANMA (Cuban newspaper), "Recuento del Primer Ano de Trabajo del Hospital Hermanos Ameijeiras," December 3, 1983, p. 4.

of Cuba's Ministry of Public Health and a strong promoter of PHC,

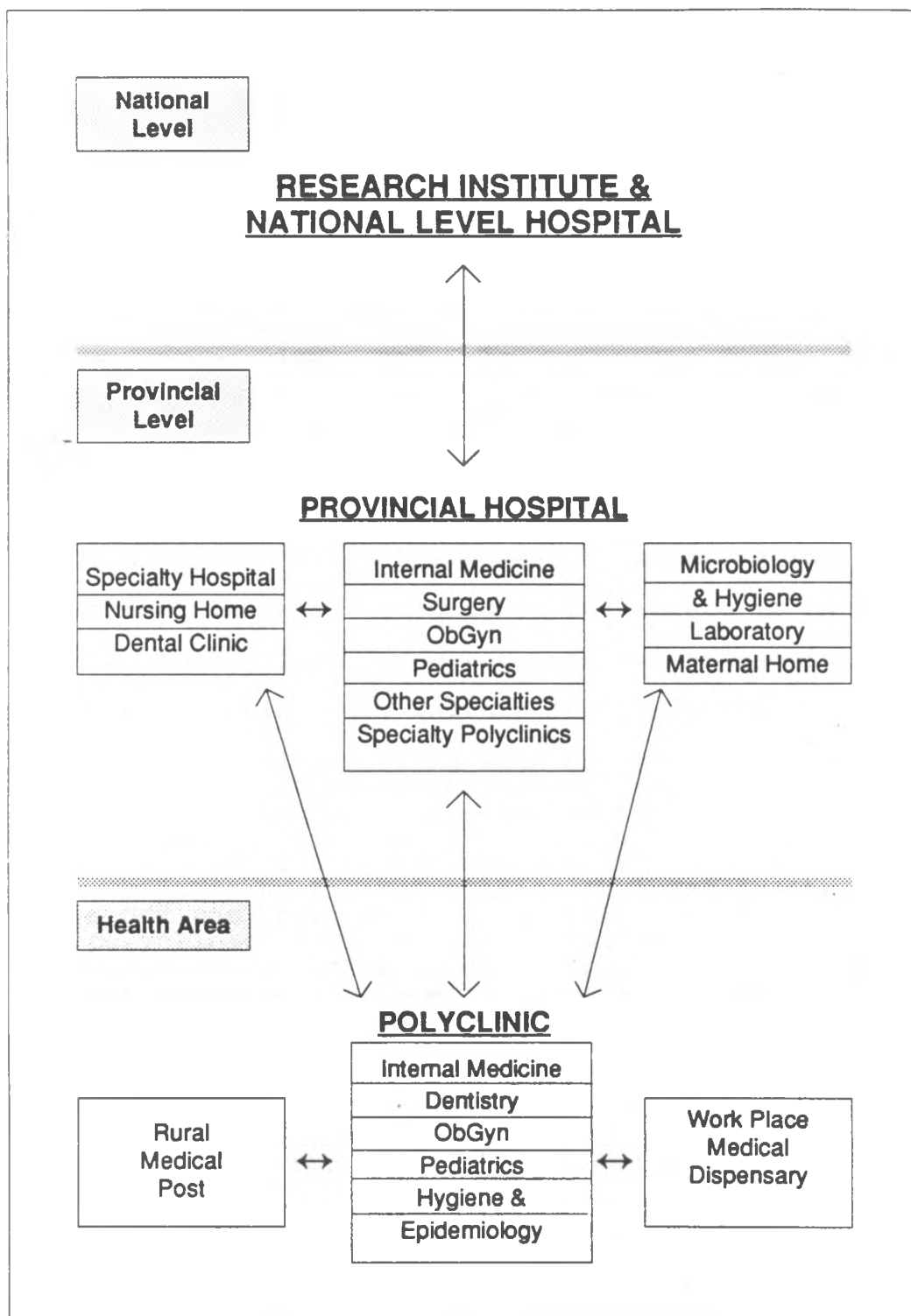
Within the Ministry of Public Health some physicians are for, and some against, making the primary level the mainstay of the health system. Obtaining support for PHC within the ministry has been very difficult.<sup>33</sup>

### Regionalization of Health Services

As stated earlier, regionalization establishes the interrelationship of the various organizational levels of the health system. To integrate the primary and secondary levels of health care, the hospital in Cuba coordinates its services with a set of polyclinics. Figure 4.2 shows the regionalized network of health services in Cuba. For the polyclinic and hospital to coordinate patient care, the primary-level physicians request consultations from secondary level physicians. The latter evaluate the patients with the former in the polyclinic. For example, the specialties of psychiatry, dermatology, and orthopedics are offered in the polyclinic by secondary-level specialists because the volume of remissions among these specialties is very high and would overburden the hospital. Other specialties such as ophtalmology and surgery are brought to the primary level for consultations when the polyclinic or rural hospital is too far away from

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<sup>33</sup>. Interview with Dr. Jose A. Gutierrez Muniz.



**Figure 4.2**  
Regionalized Network of Health Services in Cuba

Source: Ministerio de Salud Publica, Republica de Cuba, Informe Anual 1976 (La Habana, MINSAP, 1977), p.13.

the secondary level.<sup>34</sup> Also, if the patient is hospitalized, the PHC physician consults with the secondary-level physician in the hospital. In this case, the PHC physician must visit the secondary level to provide data that might affect the disease process and obtain information that will aid follow-up treatment once the patient is discharged. The patients' social data may be obtained only from the primary-level health team.<sup>35</sup> But despite multiple options to provide specialized care at the PHC level, a recent study by Dr. Carmen Valente Perez, a researcher at the Research Institute for Health Development in Cuba, established that there is hardly any control of the number of cases referred to specialty care by the polyclinic. Dr. Valente Perez reports:

All statistics dealing with the activities occurring within the health units of the National Health System must be referred to the respective Statistical Offices for planning and control. This study found that the statistical data submitted by the polyclinics included in the study was unreliable. In addition, only one polyclinic, from the six evaluated, reported the number of cases referred to specialty care. We can conclude that specialty care for ambulatory patients is an activity not controlled by the polyclinic and not planned according to need.<sup>36</sup>

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<sup>34</sup>. Interview with Dr. Elio Garrido Alvarez.

<sup>35</sup>. Carmen Valente Perez et al., "Estudio Sobre la Atencion Especializada en la Atencion Ambulatoria en Dos Municipios del Pais," Revista Cubana de Administracion de Salud 10 no. 2, (April-June 1984): 120.

<sup>36</sup>. Carmen Valente Perez et al., "Estudio Sobre la Atencion Especializada," p. 22.

Regarding referrals from the primary to the secondary level Dr. Gutierrez Muniz asserts,

We find in Cuba that many of the referrals to the secondary level could have been treated at the primary level. This situation not only overburdens the secondary level, but also hinders the proper development of the specialties at that level.<sup>37</sup>

Moreover, regarding the movement of the health team between the primary and the secondary levels, and the flow of information on patients, Dr. Luis Rodriguez Rivera, internal medicine professor at the Havana Medical School, contends,

Hospital specialists in the areas of orthopedics, dermatology, and psychiatry offer consultations in the polyclinic; however, except for these specialties the secondary level personnel never visits the primary level. We also find that patient data is not transferred from one level to the next in accordance with the admission and discharge process from the hospital.<sup>38</sup>

Inefficient coordination between the primary and secondary levels has had multiple effects on patient care and satisfaction. Because of lengthy waiting periods in the polyclinic for medical appointments, many patients skip the primary level and go directly to the emergency services of the secondary level.<sup>39</sup> Appointments are given early in the morning in the order the patient

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<sup>37</sup>. Jose A. Gutierrez Muniz et al., Fundamentacion para un Nuevo Enfoque, p. 24.

<sup>38</sup>. Luis Rodriguez Rivera, "La Importancia del Equilibrio Armonico," p. 203.

<sup>39</sup>. Interview with Elio Garrido.

arrive. Because most polyclinics offer services for eight hours daily--8:00 A.M. to 5:00 P.M.--Monday through Saturday, patients who work during the day must go directly to the secondary level.<sup>40</sup> If a patient is absent from work because of a medical appointment at the polyclinic, his or her salary is reduced accordingly with the possible exception of appointments during pregnancy and for children under one year old.<sup>41</sup> Some polyclinics offer twenty-four hour emergency services. But because many polyclinics are close to hospitals, few offer emergency services. To alleviate this problem, a new policy has been implemented extending the polyclinic's working hours until 11:00 P.M. Dr. Elio Garrido, explains,

The polyclinic working hours have been extended in four provinces, La Habana, Santiago de Cuba, Sancti Spiritus, and Cienfuegos. The following elements have been considered in the selection of provinces: population demand for the service; human resources available; and local authorities support. We still do not know what the additional cost of such policy will be; however, wherever it is needed we will implement it. Moreover, we cannot guarantee that it will be implemented islandwide. I should emphasize that the population did not openly request extending the working hours of the polyclinic.<sup>42</sup>

Another element influencing the patient's decision to skip the primary level is that traditionally in Cuba the better-qualified physicians have been concentrated in the

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<sup>40</sup>. The work week in Cuba covers Monday through Saturday for two weeks each month, and from Monday through Friday the remaining two weeks of the month.

<sup>41</sup>. Interview with Dr. Ignacio Macias Castro.

<sup>42</sup>. Interview with Elio Garrido.

hospitals, not in the polyclinics. Thus the population developed a higher esteem for hospital centers and curative medicine.

Another constraint to the regionalization process in Cuba is the territorial location of the health units at the three levels of health care.<sup>43</sup> Surprisingly, for a centrally planned economy such as Cuba's, its health services regionalization network does not respond to a planning process that includes the specific needs of the province despite the establishment of standards for health planning in 1977. These standards introduced criteria to establish the geographic location of polyclinics--number of inhabitants, communications network, population concentration, and economic development projections for the area.<sup>44</sup> Since 1981 research studies have been undertaken to obtain data to support the planning process for the health institutional network.<sup>45</sup> Many polyclinics are located in structures such as residential houses or poor houses, left behind by those who abandoned the country after the Revolution.

In Cuba, the coordination implicit in the regionalization concept between the secondary-level hospital and the polyclinic at the primary level is not developed to the

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<sup>43</sup>. Pedro Llerena, "Address: Regionalization of Health Services in Cuba," in MINSAP/WHO, International Conference Health for All.

<sup>44</sup>. Interview with Elio Garrido.

<sup>45</sup>. Pedro Llerena, "Address."

same degree among the teaching and nonteaching polyclinics. This results from the higher number of specialties offered in the teaching polyclinic and the lack of control over the number of cases referred to specialty care by the polyclinic. Such lack of coordination underscores the importance of an integrated subsystem of emergency services among the three levels of health care. A register of the morbidity pattern is equally crucial to forecast the actual volume of ambulatory patients in the primary level and plan accordingly for future PHC facilities. Most important, if the secondary and tertiary levels are not adequately linked to the primary level, the former will continue to undervalue the psychological and social aspects of health, and a preventive emphasis will not develop.

### Popular Participation

The improvement of health indices in Cuba has relied to a considerable degree on the participation of mass organizations in the implementation of health programs at the primary level. These mass organizations have participated in the implementation of national campaigns dealing with vaccinations, environmental hygiene, blood donations, detection of health problems at the local level, massive medical exams of the population, epidemiological control of contagious diseases, and



legalization of voluntary donations of organs and tissues.<sup>46</sup>

One way mass organizations participate is through the People's Health Commissions, which are the institutionalized form of popular participation in health matters. Aside from their representation at the municipal, provincial, and national level, they also have the responsibility for the corresponding administrative level of People's Power, (see Figure 4.1).

At the primary level, the People's Health Commissions consist of (1) the polyclinic director and other members of the Polyclinic Directive Council, such as the chief of nursing, chief of social work, and so on; (2) the individuals responsible for health actions in the Committees for the Defense of the Revolution (CDRs), the Federation of Cuban Women (FCW), and the National Association of Small Farmers; and (3) occasionally People's Power delegates and Ministry of Public Health officials. Their main responsibilities are to administer health services and implement health policy and programs. The People's Health Commissions meet once a month, and in these meetings they (1) evaluate whatever health activities have been undertaken in the community during

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<sup>46</sup>. Interview with CDR officials in the National Office of the Committees for the Defense of the Revolution, La Habana, Cuba, July 21, 1983.

that month; (2) discuss with the health officials on the commission specific health problems confronted by the health representatives of the mass organizations in the areas under their jurisdiction; and (3) discuss the health area assessment completed by the Polyclinic Directive Council. Subsequently, the health officials on the commission determine which problems the community can help solve although some input from mass organizations representatives is considered.

An activity called Meeting with the Community takes place exclusively in teaching polyclinics two to four times a year. In the words of Dr. Sergio R. Ledo Duarte, a Ministry of Public Health official,

The main objective of "Meeting with the Community" is to establish a closer link between the polyclinic health team and the community. The meeting is used for two purposes: first, to analyze the health sector assessment made by the physician in charge of that specific sector; and, second, for an exchange of ideas between the health team of the sector and the community about what the health team considers to be the essential elements affecting health in that area. Whatever health problems are voiced by the community, the health team reports such problems to the appropriate organizations for its solution.<sup>47</sup>

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<sup>47</sup>. Sergio R. Ledo Duarte, "Participacion Popular en Salud," Revista Cubana de Administracion de Salud 10, no. 3, (July/September 1984): p. 222. It would have been of great help to attend a People's Health Commission or Meeting in the Community session to observe the interaction between the community and the health team; however, the author was told by Ministry of Health officials that none were being held throughout the time she would spend in Cuba.

Health Meetings is a highly successful activity held once a month between the community and the health sector physician in which he or she explains the health strategies implemented in the sector. The main purpose is to increase knowledge and support for such health strategies.

Popular Health Schools are held once a year in the polyclinic to teach the individuals responsible for health activities within the Committees for the Defense of the Revolution how the community can help solve health problems. Courses in health education are also taught by the members of the Polyclinic Directive Council.

Another form of community participation in health is the Health Brigades. The Health Brigades Program is coordinated by the Federation of Cuban Women and the Ministry of Public Health and is formed of women from the community who become involved in health tasks as requested by the polyclinic staff. They keep a list of the women on their block and a record of the appointments these women are supposed to keep in the primary level for (1) annual gynecological exams; (2) monthly appointments during pregnancy; and (3) appointments for under one-year-olds. If they do not keep their appointments, the representative of the health brigade visits them to urge them to attend. Thus the main role of the health brigade is to help enforce health programs through the continuous surveillance of women in the community. In each block there are one or more members of the health brigades. A Health Brigades Sector consists of four or five blocks

and is directed by a health brigades chief, who is charged with the implementation of the program in that sector.

The Health Brigades Chief within the Polyclinic Directive Council is the director or subdirector of the Nursing Department. Members of the health brigades are trained periodically through courses offered by the health team in the polyclinic.<sup>48</sup>

The review of the multiple activities in which mass organizations participate at the primary level in Cuba reveals one common feature despite the Health Brigades, the Health Meetings, and the Popular Health Schools, the Cuban approach to community participation relies heavily on medical experts to define, manage, and evaluate public participation. By and large, the result has been professional direction of community activities. The dominance of the medical profession in this approach results in the view that the community can follow orders to improve community health conditions when given detailed instructions. But, the medical profession is considered to be the only one capable of deciding in which activities the community can be involved.<sup>49</sup> Structures like the People's Health Commissions and the Health Brigades in

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<sup>48</sup>. Interview with Catherine Ribas, official of the National Office of the Federation of Cuban Women, La Habana, Cuba, July 21, 1983. Unfortunately, the meetings held through the health meetings, popular health schools, and health brigades were not made available to this researcher.

<sup>49</sup>. Susan B. Rifkin, "Role of the Public in the Planning, Management, and Evaluation of Health Activities," pp. 378-79.

Cuba are created with professional control so that these groups can influence the community to support professionally defined activities. Following this strategy, the role of the community in planning health activities at the primary level in Cuba is minimal or nonexistent. Planning is done by the experts, who in their judgment best understand the complexities of the health situation. Activities such as Meeting with the Community and having representatives of mass organizations in the Polyclinic Directive Council are used to consult with mass organizations who are instrumental in implementing the medical experts' plan. Most important, since 1980 rigorous selection for new members in the CDRs and FCW following political-ideological development has been instituted, limiting mass participation and local democracy in health affairs.

### Innovations

In January 1984, an innovation to the PHC model in Cuba was implemented on an experimental basis in one section of the "10 de octubre" municipality in the City of Havana province. It is called the Physician for the 120 Families program. The model consists of assigning 120 families to each of the ten physicians involved in the program. Each physician provides care in the PHC unit during the morning hours and within the families' homes in

the afternoon. The main purpose is to integrate curative and preventive activities and to focus on the socio-economic factors affecting the etiology of disease.<sup>50</sup>

It seeks to overcome the deficiencies of the Community Medicine Model and if it is implemented islandwide it will complement, not replace, the Community Medicine Model.

Although Cuba has a very high ratio of physicians to population, with one physician for every 583 inhabitants in 1982, it is questionable whether enough resources will be available to implement the program islandwide.

## Achievements and Constraints

### First-Contact Care

The main element affecting first-contact care in Cuba is the physician/patient ratio. There is a striking difference between teaching polyclinics and non teaching polyclinics. Such differences are reflected in the number of patients sectorized and under "control" in each type of health unit. As we have seen, the result is an average coverage of 80 to 90 percent of the population assigned to a teaching polyclinic, whereas there is only 40 to 50 percent coverage by the non teaching polyclinic. Teaching

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<sup>50</sup>. GRANMA (Cuban Newspaper), "En Torno al Programa Experimental El Medico de las 120 Familias: Los Centinelas de la Salud," January 17, 1984, p. 3.

polyclinics are available to only 10 percent of the urban population. Thus, 90 percent of the urban population in Cuba is receiving PHC from non-teaching polyclinics. It can be inferred that an average of 50 percent of the urban population in Cuba actually uses the primary level as the point of entrance to the health system.

A similar problem is observed in the rural areas, where a study undertaken in two Cuban provinces showed accessibility to be inadequate. The medical rural institutional network in both provinces did not correspond with the population distribution. Surprisingly, four health areas provided PHC to populations of over thirty thousand inhabitants; while the Cuban standard for a rural health area is five to seven thousand inhabitants.

Both instances have to do with inadequacies in the planning process for the health services regionalization network, which does not respond to the specific characteristics of the province, particularly the number of inhabitants. Despite the ever increasing number of physicians in Cuba, little effort is made to assign more physicians to the primary level, with the possible exception of the new PHC model, Physician for 120 Families, which is still an experimental project. Moreover, the fact that the CMM is available to 80 percent of the population refutes the conventional literature that states that the CMM is accessible to 100 percent of the Cuban population.

The inefficient coordination between the primary and secondary levels, has had multiple effects, particularly on use patterns. Many patients skip the primary level and go directly to the secondary level.<sup>51</sup> An influential element has been the long waiting periods to see a physician in the polyclinic. Moreover, polyclinics and rural hospitals offer services for only eight working hours daily.<sup>52</sup> Unless the facility has twenty-four-hour emergency services available, patients are forced to go directly to the secondary level.

#### Coordination of Care

Continuity in medical records deeply influences coordination of care. In Cuba, the internal medicine, pediatrics, and OBGYN health teams keep in their offices their own files with patients' records belonging to their sectors. They also keep card files with appropriate flags indicating high-risk patients by risk category. Following the "dispensarization" or "control" concept, a register is established for patients with chronic and acute conditions.

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<sup>51</sup>. Perez et al., "Estudio Sobre la Atencion Especializada," p. 22.; Muniz et al., Fundamentacion para un Nuevo Enfoque de la Medicina, p. 24; Rivera, "La Importancia del Equilibrio Armonico," p. 203.

<sup>52</sup>. Interview with Elio Garrido.



Continuity in medical records also depends on coordination of the hospital-polyclinic relationship between the primary and secondary levels. In Cuba, however, patients' information is not transferred between the primary and secondary levels in accordance with the admission and discharge process from the hospital. This hampers coordination.<sup>53</sup>

Another factor influencing coordination of care is continuity by the physician or health team. Even though teamwork is an essential feature of the CMM, most of the time there is no coordination among the members of the horizontal and vertical primary teams.<sup>54</sup> The "control" concept assures continuity of care by the health team for individual programs, although it does not help interrelate the four Health Basic Programs. Indeed, the actions undertaken by the health teams in each of the Health Basic Programs are not integrated by the health team but by the polyclinic director or the chief of the Statistics Department. Less than half of the population has been medically assessed and placed in "control."<sup>55</sup> For this group, however, the health team is very aggressive in its effort to provide follow-up care.

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<sup>53</sup>. Rivera, "La Importancia del Equilibrio Armonico," p. 203.

<sup>54</sup>. Muniz et al., Fundamentacion para un Nuevo Enfoque, p. 31.

<sup>55</sup>. Interview with Dr. Ignacio Macias Castro.

The manner in which the health areas are divided by sectors to facilitate the work of the physician/nurse teams assures that for those patients actually seen, health problems will not go unrecognized. These teams are responsible for all health sector activities of the patients belonging to the sector, whether they are diseased or not. As stated earlier, the problem is that not all patients are seen because of an imbalance in the physician/patient ratio.

#### Comprehensiveness

To achieve comprehensiveness, the PHC unit must be able to arrange for the patient to receive all types of health care. In Cuba, the horizontal and vertical health team in the PHC unit facilitates referrals to specialized or highly specialized care, home care, and homes for the elderly. The regionalized health system also helps this process, despite such faults, as the inability to control the number of referrals to the secondary level and referring patients to the secondary level who could have been taken care of in the primary level.

To achieve comprehensiveness, the unit staff must also know and be able to explain to the population under their care the health services for which they are responsible. In Cuba, the wide participation of mass organizations in the implementation of health programs forces the unit

staff to explain to the population the types of health programs offered in the PHC unit.

Other elements required for the achievement of comprehensiveness are the presence of preventive and curative activities and the ability to recognize problems, whether organic or social. The basic PHC model in Cuba, the CMM, promotes both curative and preventive actions for health. This does not necessarily mean, however, that a preventive emphasis at the primary level is present. Most of the health actions are geared toward acute or chronic diseases; are not aggressive promote preventive activities for those who are not diseased.<sup>56</sup> Moreover, the Cuban PHC physicians still emphasize curative medical activities even though in the one year of clinical training required for medical students at the PHC level psychological and social factors are stressed.<sup>57</sup> Preventive actions are strongest in the continuous surveillance of pregnant women and children under one year old, in assuring that women take their annual gynecological exams and in the health education component within the Health Basic Programs. They rely on the nurse and the physician as health educators; the results particularly with the physician have been discouraging.<sup>58</sup>

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<sup>56</sup>. Interview with Dr. Ignacio Macias Castro.

<sup>57</sup>. Rivera, "La Importancia del Equilibrio Armonico," pp. 200 and 204.

<sup>58</sup>. Interview with Dr. Carmen Santos.

It sums clear that in spite of the research studies undertaken to reinforce the primary level, if the current trend continues, a curative emphasis will prevail. The power of the medical structure will resist any major shifts in emphasis to preventive actions, for that would threaten the hegemonic power of physicians over their view of good health, which is based on the application of medical science and technology and disregards the importance of social elements in the etiology of disease.

### Longitudinality

The extent to which the PHC facility can identify its eligible population and that the population recognizes the PHC unit as a regular source of care is crucial to the fulfillment of longitudinality. In Cuba, the number of inhabitants the PHC unit must serve in the urban and rural areas is very well delineated. But although patients recognize that they should enter the health system at the primary level, they prefer to go directly to the emergency room of the secondary-level hospital.<sup>59</sup>

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<sup>59</sup>. Interview with Elio Garrido.

## Conclusions

This chapter has established that unlike most LDCs, Cuba has successfully made available PHC services to most of the population regardless of socioeconomic status. A wide array of curative and some preventive services are available at the primary level. But primary levels have not been effectively coordinated with secondary levels, thereby hampering use patterns. The result has been that patients skip the primary level and go directly to the secondary level. Equally, although keeping medical records assures continuity of care patients information is not efficiently transferred between levels of care because of deficiencies in the establishment of regionalization as a process and in the health planning process. Continuity of care by the health team in Cuba is very aggressive and seeks the patients in their homes whether they are diseased or not.

Cuba was able to improve health indices dramatically because morbidity and mortality rates were mainly a result of infectious diseases. Therefore, if the health indices are to be maintained and improved new PHC models with a strong preventive component capable of dealing with chronic diseases will have to be devised. Most likely, this awareness motivated the Physician for 120 Families experiment.

## CHAPTER V

### DELIVERY OF PRIMARY HEALTH CARE IN COSTA RICA

Whereas there is a reasonable amount of information on the Cuban health care system, the Costa Rican system is hardly ever discussed in the health literature, which is surprising because Costa Rica has achieved many improvements in the health status of its population. The main goal of this chapter is to discuss the delivery of primary health care in Costa Rica.

Following the framework of Chapter IV, this chapter analyzes whether the essential features for PHC delivery are observed in Costa Rica. The chapter is divided in two sections. The first section describes the PHC strategy implemented in Costa Rica, and the second discusses the delivery of PHC.

### COSTA RICA'S STRATEGY

Unlike Cuba, Costa Rica does not have a unified National Health System. The Costa Rican Social Insurance Fund (CCSS) is in charge of nearly all curative medicine offered to workers covered under the CCSS, the indigents, and low-income groups. The Ministry of Health is charged with the programs included under PHC, which include the Rural Health Program (RHP) for low-income groups living in the rural areas; the Community Health Program (CHP) for

low-income groups living in urban slums, and the Popular Participation Program.<sup>1</sup>

### Rural Health Program

The Rural Health Program (RHP) provides basic health services to rural areas with fewer than 2,400 inhabitants, but gives special emphasis to dispersed communities with fewer than 500 inhabitants. The program includes direct services to individuals, environmental health activities, and complementary support services. Direct services to individuals involves (1) control of communicable diseases that are preventable by vaccination, tuberculosis, and intestinal parasites; (2) epidemiological surveillance of malaria; (3) child and maternal health; (4) nutrition; (5) family planning; (6) dental health; (7) first-aid care; and (8) patient referral. Environmental health actions include (1) building small reservoirs and pipelines to provide drinking water; (2) latrinization; (3) improvement of rural housing; and (4) vector control. Complementary support services include the promotion of community organization and health education.<sup>2</sup>

The program is delivered through "rural health areas," each of which includes an average of 2,400

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1. Lenin Saenz, "Health Changes during a Decade: The Costa Rica Case," in Halstead et al., eds. Good Health at Low Cost, p. 251.

2. Ibid.

inhabitants. By 1982, there were a total of 294 health areas covering 722,778 inhabitants.<sup>3</sup>

A Health Post is located in each area under the supervision of an auxiliary nurse or a rural health assistant. The auxiliary nurse must visit the households near the health unit; the rural health assistant is charged with home visits in the most distant localities of the health area. Both categories of personnel must provide care to patients with simple ailments and first-aid care. They are also in charge of communicable disease control, environmental health, and health education. In addition, they must complete a periodic census of the health area to obtain information about the specific problems of the population. The rural health assistant must draft a rough sketch of his or her health area using the information obtained in the census. They must also keep a record for each household with information on the physical characteristics of the household and general and health information on each member of the family. Supposedly, the health personnel visits each household four times annually and tours the area house-to-house within a period of two months.<sup>4</sup> According to Maria Eugenia Dondi, national supervisor of the Community and Rural Health Program,

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<sup>3</sup>. Costa Rica, Ministry of Public Health, "Rural Health Program," mimeograph, 1982.

<sup>4</sup>. Government of Costa Rica, Costa Rica: Extension of Coverage of Health Services within the Framework of Socio-economic Development, Proceedings of the International Conference on Primary Health Care in Alma-Ata, USSR, September 6-12, 1978, p. 31.



whether households are visited four times annually depends on the efficiency of the health worker. Not all of them work with the same dedication.<sup>5</sup>

The training undertaken by the rural health assistants lasts from nine to twelve months. There has, however, been strong opposition from medical professionals to the use of auxiliary personnel for such activities. In the words of Dr. Carlos Munoz, director of the Rural Health Program,

Physicians in Costa Rica have been against the use of lay personnel to provide health care in the rural areas. They do not consider them capable of providing health care in the home and executing the following health actions: vaccinations; collection of blood and saliva samples; surveillance of pregnant women and children; blood pressure measurement; family planning; and case referrals to higher levels of care. In fact, physicians have labeled them as, "the official medical quacks." Physicians do not understand that given our present economic situation it is the only alternative available in Costa Rica to provide PHC in the rural areas.<sup>6</sup>

Health Posts are built from low-cost units, or existent structures are reconditioned for such purposes. They are equipped with the necessary supplies to provide basic health services and are supposed to be resupplied every three or four months with vaccines, drugs, and other

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5. Interview with Maria Eugenia Dondi, national supervisor of the Community and Rural Health Program, Ministry of Health, San Jose, Costa Rica, August 10, 1983.

6. Interview with Dr. Carlos Munoz, director, Rural Health Program, Ministry of Health, San Jose, Costa Rica, August 11, 1983.

materials.<sup>7</sup> When this researcher was in Costa Rica, however, rural health assistants complained of lack of supplies. This situation was also prevalent in the CCSS health units of the secondary and tertiary levels of care and is a reflection of the economic crisis in Costa Rica.

The professional staff of a Health Post supports and supervises several health areas in the same geographical area. Supervision is exercised at the technical level by nurses, dentists, and physicians who are specifically concerned with family planning and curative care. Every two or three weeks the physician comes into the Health Post to provide care to patients referred by the auxiliary nurse or rural health assistant. The physician also refers patients requiring specialized care to the hospitals and outpatient clinics. The physicians in the rural areas in Costa Rica are recent graduates who are completing their compulsory year of service in the rural area. Dr. Carlos Munoz contends,

One of our biggest concerns is that at this time the health service has not integrated preventive and curative care. There is a lack of coordination between levels of service which impedes the flow of patients from the primary to the tertiary level. This is a very serious problem, particularly for that sector of the population not covered by health insurance, namely ten to fifteen percent. They have serious accessibility problems.<sup>8</sup>

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7. Ibid.

8. Ibid.

Even though the RHP assigns financial resources to the CCSS to ensure their medical and hospitalization benefits as state insurants the referral problems are prevalent.<sup>9</sup>

The health actions implemented in 1973 within the RHP have remained unchanged and have not been adapted to the new health situation of the country. Moreover, budgetary reductions at the start of the 1980s led to a reduction in coverage. Accordingly, the RHP reduced its coverage from 60 percent of the rural population in 1979 to 57 percent in 1982.<sup>10</sup>

### Community Health Program

The Community Health Program (CHP) was instituted in 1976 and patterned after the RHP on the assumption that the population forming the urban slums had migrated from the rural areas. The program's main objective is to provide preventive health care. The basic health services offered are similar to those of the RHP: (1) provision of care to patients with simple ailments and first-aid care; and (2) control of communicable diseases, environmental health, and health education.

The CHP is developed through various stages. Initially, a diagnosis is completed to determine the need

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<sup>9</sup>. Lenin Saenz, "Health Changes during a Decade," p. 251.; and interview with Dr. Carlos Munoz.

<sup>10</sup>. Lenin Saenz and Hazel Martinez, Aspectos Demograficos de la Atencion Primaria en Salud (San Jose, C.R.: Asociacion Demografica Costarricense, 1983), p. 5.

to establish a "community health area." Such areas cover a population of between 2,300 and 2,600 inhabitants. The criteria for the establishment of such areas are economic and social marginality, availability of health programs, priority of their problems in relation to national strategies, and the availability of access routes. Each health area has a health center that serves as the operations base. The next hierarchical level is the programmatic region office. At the central level in the Ministry of Health, the CHP consists of a medical director, two supervising nurses, and an administrator.<sup>11</sup> A program evaluation executed by the Ministry of Health of Costa Rica in 1982 showed that

strong control of the CHP by the central level and the lack of decision-making power in the regional offices and the health centers have promoted operative and administrative problems which hinder program execution.<sup>12</sup>

The CHP is implemented in the home by community health assistants, who undergo three and a half months of training. These assistants respond directly to the chief nurse and chief physician of the community health center, although some centers have a nurse in charge of the program. The main problem the CHP has encountered is that the community health assistants lack job motivation and

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<sup>11</sup>. Interview with Mary Morales, nursing supervisor for community health, Ministry of Health, San Jose, Costa Rica, August 17, 1983.

<sup>12</sup>. Costa Rica, Ministerio de Salud Publica, Evaluacion General del Programa de Salud Comunitaria (San Jose, C.R.: Ministerio de Salud, 1982), p. 10.

interest in achieving program objectives. Maria Eugenia Dondi, national supervisor of the Community and Rural Health Program, reported:

Community health assistants consistently complain that the rest of the members of the health team do not back them given that some physicians and nurses are against the CHP. The CHP supervisors seldom supervise and when they do, they focus on criticism that does not help the assistants reduce their deficiencies. Moreover, most of them take this job because there is not one better and community health assistants cannot be promoted within the hierarchical structure of the Ministry of Health. In addition, they complain of lack of materials and equipment.<sup>13</sup>

The CHP evaluation mentioned above showed other constraints:

Community health assistants consider their initial training was inadequate and continuing education has not been provided except when new activities are incorporated to the program. Moreover, they feel frustrated because they argue that once hired they were promised additional training to become a nurse auxiliary with the corresponding improvement in status and salary, and this training has never been offered. Lastly, they complain of the household records they must fill out daily contending they are long and tedious, and they are never informed of the results.<sup>14</sup>

Costa Rica is divided into health regions to facilitate the operation of the health care system, and its seven provinces (Alajuela, Cartago, Guanacaste, Heredia, Limon, Puntarenas, and San Jose) are distributed among these regions; sometimes a province is divided between two or three regions. The highest number of

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<sup>13</sup>. Interview with Maria Eugenia Dondi.

<sup>14</sup>. Costa Rica, Ministerio de Salud Publica, Evaluacion General del Programa, pp. 12-13.

health centers are found in the central region, the location of the capital city, San Jose. By 1982, the CHP covered 49 percent of the urban marginal community.<sup>15</sup> Table 5.1, shows the distribution of health centers by regions. According to the national supervisor of the CHP,

Presently, the CHP cannot keep up with the growing number of slums appearing in the San Jose area due to increasing numbers of people migrating from the rural areas, in addition to migrants arriving from Nicaragua, El Salvador, and Guatemala who want to escape the Central American conflict.<sup>16</sup>

Finally, the CHP shows deficiencies in the information processing mechanism. Although computerized information is available, it is not processed or distributed. In fact the only activity undertaken is the numerical tabulation of activities which is done manually at the central level.<sup>17</sup> Costa Rican health specialists argue that the CHP should be strengthened. Dr. Juan Jaramillo Antillon, former minister of health of Costa Rica, argues,

At this time, it is extremely important to fortify the CHP since national health indicators and economic and social conditions have started to deteriorate given the economic crisis and the

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15. Saenz and Martinez, Aspectos Demograficos, p. 5.

16. Interview with Maria Eugenia Dondi.

17. Costa Rica, Ministerio de Salud Publica, Evaluacion General del Programa, p. 14.

Table 5.1

Distribution of Community Health Areas in Costa Rica  
by Regions, Health Centers, and Population  
1982

Region	Number of Areas	Number of Health Centers	Population
Central	93	19	180, 686
Huetar Norte	57	15	129, 523
Chorotega	42	10	88, 901
Huetar Atlantica	48	7	113, 455
Brunca	7	3	15, 086

Source: Costa Rica, Ministerio de Salud Publica,  
Evaluacion General del Programa de Salud  
Comunitaria (San Jose, C.R.: Ministerio de  
Salud, 1982), p. 6.

increased demand for such services. However, it is unlikely that financing will increase because the country is in a precarious economic situation.<sup>18</sup>

### Regionalization of Health Services

The most distinctive feature of the regionalized health care system in Costa Rica is that the three levels of care are not unified into one health care system. On one hand, the primary level is administered by the Ministry of Health and provides basic and preventive health actions. These services are offered by auxiliary health personnel and by the physician in the Health Center operated by the Ministry of Health. The physician makes scheduled visits to the Health Post. Referrals to higher-level care are arranged when necessary. On the other hand, general and specialized medical care are offered by the CCSS. The CCSS includes the three highest levels of medical care: (1) general medical care in the Health Centers of the CCSS, which provide ambulatory care by general physicians, dentists, nurses, laboratory services, environmental sanitation, and social services; (2) general and specialized medical care in the regional hospitals; and (3) highly specialized medical care in the

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<sup>18</sup>. Interview with Dr. Juan Jaramillo Antillon, Minister of Health, 1982-1986, Ministry of Public Health, San Jose, Costa Rica, June 9, 1985.



national hospitals.<sup>19</sup> An illustration of the three levels of care in Costa Rica can be seen in Figure 5.1.

The regionalization framework should promote the flow of patients through the health system by sending patients from the Health Posts to the Health Centers and from there, if necessary, to the regional or national hospitals. These secondary and tertiary facilities would return the sick after treatment or diagnosis with the corresponding clinical histories summarized and their treatment to guarantee follow-up care in the periphery.<sup>20</sup> But this route is not followed as is clear from the following statement by Dr. Juan Jaramillo Antillon:

There is an urgent need to coordinate the activities of the health units within each of the regions. Presently, there is no communication network between levels of health care in the Ministry of Health and the CCSS. In fact, even within the levels of curative health care belonging to the CCSS patients skip the primary and secondary level and go directly to the tertiary level. In this respect, one of our main problems is lack of personnel trained in administrative matters.<sup>21</sup>

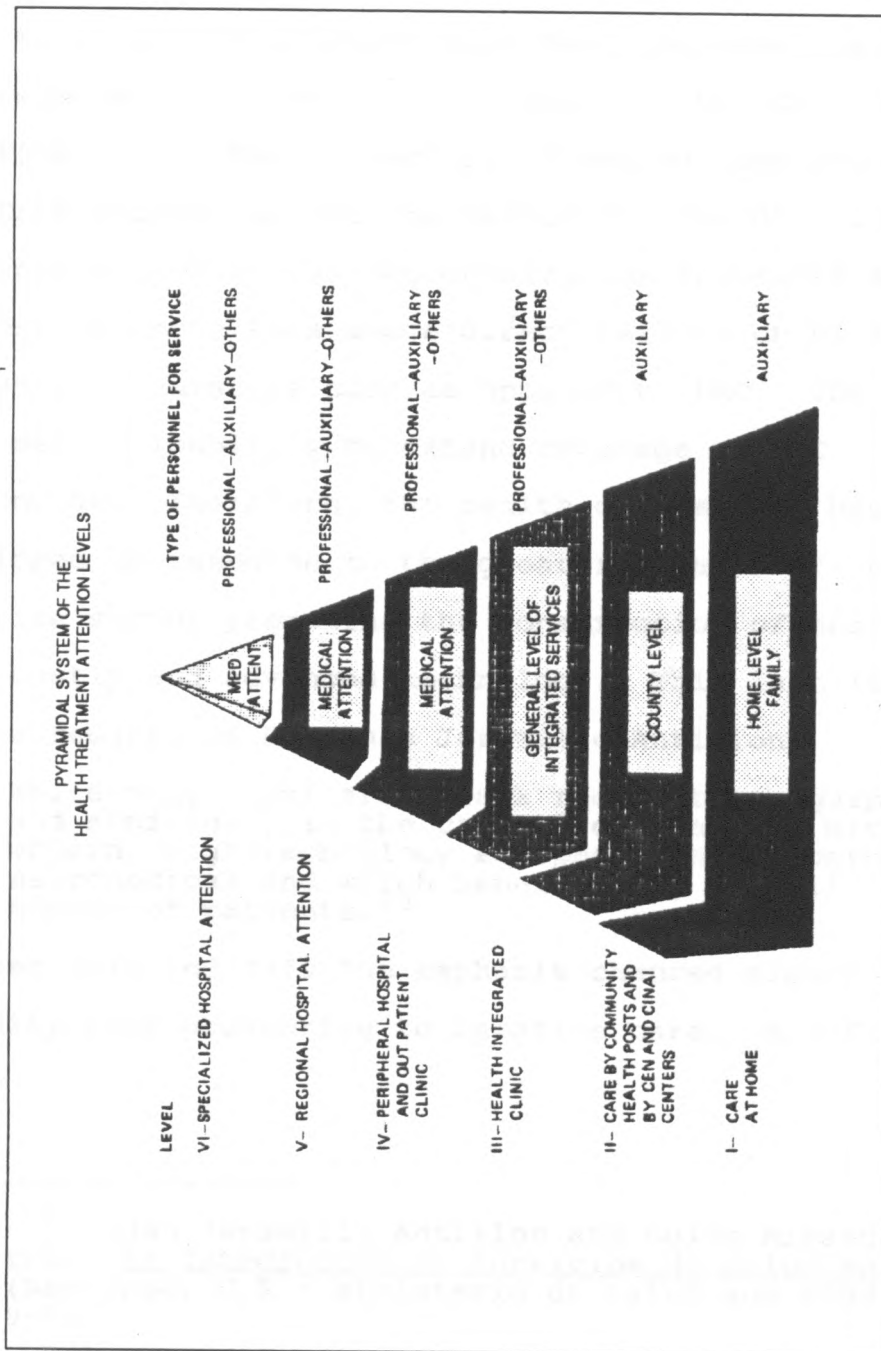
Most important the regionalization scheme of the Ministry of Health differs from that of the Social Security System, making the integration of efforts increasingly difficult. For example, referrals between levels of care among differing regions are problematic. Further, both

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<sup>19</sup>. Juan Jaramillo Antillon, Los Problemas de la Salud en Costa Rica: Politicas y Estrategias (San Jose, C.R.: Organizacion Panamericana de la Salud, 1984), p. 72.

<sup>20</sup>. Interview with Dr. Juan Jaramillo Antillon.

<sup>21</sup>. Ibid.



**Figure 5.1**  
**Regionalized Network of Health Services in Costa Rica**

**Source:** Government of Costa Rica, Costa Rica: Extension of Coverage of Health Services Within The Framework of Socio-Economic Development p. 24.

regionalization schemes differ from the Ministry of Planning's regionalization framework. Thus coordinated work to construct a health plan that includes inputs from the regions of the Ministry of Health, the CCSS, and MIDEPLAN in the Health Sectoral Planning Subsystem in MIDEPLAN becomes almost impossible.<sup>22</sup> The difficulties in the institution of the regionalization framework and process in Costa Rica are a direct reflection of the emphasis on curative care as opposed to PHC. The result has been an inability to extend coverage of PHC nationwide. Therefore, the health care system has developed in response to the greater demands of the curative sector promoting the construction of hospitals with costly and advanced technology. This fact is evident in the remarks of Dr. Juan Jaramillo Antillon:

While many rural areas lack rudimentary equipment and medicines, in the capital city abound ultra-modern, high-technology equipment whose costs are astronomical and which benefit only a small number of patients.<sup>23</sup>

Between 1970 and 1979 the emphasis changed slowly but steadily from preventive to curative care. A reflection of

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22. Juan Jaramillo Antillon and Guido Miranda Gutierrez, La Integracion de Servicios de Salud en Costa Rica (San Jose, C.R.: Ministerio de Salud and CCSS, 1985), pp. 19-20.

23. Interview with Dr. Juan Jaramillo Antillon. For more information on the importance given to curative medicine in Costa Rica see Dr. Fernando Sell Salazar, "Nuestro Hospital Nacional de Ninos," La Nacion (Costa Rican newspaper), February 10, 1985, p. 16A.

this shift is the health expenditures of the CCSS, whose emphasis is curative, versus those spent by the Ministry of Health, which is charged with preventive health actions. Table 5.2 shows the change in annual health expenditures between 1970 and 1979 for the Ministry of Health, the CCSS, and the Institute of Water and Sewers (which also belongs to the health sector). In 1973 the CCSS began to absorb a higher percentage of the health budget, until by 1979 it had reached 71 percent, while that of the Ministry of Health had decreased to 17 percent. In the 1980s, the situation has worsened. For example, in 1982 the CCSS was responsible for 75 percent of the nation's total health expenditures and the Ministry of Health's share declined to 12 percent.<sup>24</sup>

### Community Participation

Although popular participation in health is considered to be a basic component of specific programs such as rural health and community health, it is an independent administrative unit within the Ministry of Health, presently, called the Community Promotion and Development Department. In Costa Rica, community participation is "encouraged" through various development associations and

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<sup>24</sup>. Carmelo Mesa-Lago, "Health Care in Costa Rica," p. 20; see also, "Aseguran que Urge Revision de Nuestro Esquema de Salud," La Nacion, March 22, 1985, p. 2A.

Table 5.2

Percentage Distribution of Total Health Care Expenditures  
by Agency in Costa Rica,  
1970-1979

Years	Ministry of Health	CCSS	Aqueduct and sewage
1970	46	43	11
1971	50	38	12
1972	46	42	12
1973	42	46	12
1974	43	44	13
1975	38	47	14
1976	32	52	16
1977	24	63	13
1978	18	71	11
1979	17	71	12

Source: Lenin Saenz et al., Salud en Costa Rica: Evaluacion de la Situacion de la Decada de los Anos 70 (San Jose, C.R.: Ministerio de Salud Publica, Unidad de Planificacion, 1981), p. 173.

committees. Examples of such organizations are the Health Committees and Sub-Committees in the health areas and the Municipal Health Associations established in the municipalities. Some of these associations are legally authorized to collect income tax from community members to cover the costs of their programs. Development associations may also borrow money and accept donations to raise funds for the programs. Community delegates periodically meet with the field personnel to analyze progress and options for improvement.<sup>25</sup>

Within the rural health program, the community participation strategy is to use volunteers, who are called individuals responsible for health activities<sup>26</sup> and are trained in Basic Health Programs. They are in charge of detecting pregnant women within the community and informing the auxiliary nurse in the rural health post. They have also been designated as information and surveillance agents. Within the Community Health Program, Health Centers Committees have been established to help collect money from community members to finance the health center. The essence and main goal of community participation in Costa Rica are expressed in the remarks of Alvaro Rodriguez Cerdas, director of the Community Promotion and Development Department,

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<sup>25</sup>. Saenz, "Health Changes during a Decade," p. 252.

<sup>26</sup>. This is a literal translation of what they are called in Spanish: "responsables de salud."

When the 1982-1986 government administration took power in Costa Rica they did not want to get involved in the Popular Participation Program because it was infiltrated with individuals of communist ideology. Such individuals were causing multiple problems within the communities. Once the new minister of health came in, he requested restructuring the program and we even changed its name from Popular Participation Program to Community Promotion and Development Department to avoid the "communist connotations" of popular participation. We do not pretend to be McCarthyists, but now our main concern is to keep communists out of the committees. To do so, lists of proposed committee members are sent directly to the minister of health for approval.<sup>27</sup>

Therefore, in Costa Rica community participation is limited to financing and implementation of some health activities. Although officially it is recognized that the participation of the community is important in the implementation of PHC, the community is not integrated into the decision-making process.<sup>28</sup> Moreover, most health officials believe that using the community to finance and implement some health activities promotes paternalism and dependency. The lack of a well organized framework to define the role of participation in the different PHC programs has also promoted limited community participation.<sup>29</sup>

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27. Interview with Alvaro Rodriguez Cerdas, director of the Community Promotion and Development Department, Ministry of Health, San Jose, Costa Rica, August 11, 1983.

28. Alvaro Rodriguez Cerdas, Filosofia de la Promocion y Fomento Comunal dentro de las Acciones de Atencion Primaria (San Jose, C.R.: Ministerio de Salud, 1983), pp. 1-2.

29. Costa Rica, Ministerio de Salud, Evaluacion General del Programa, p. 9.

After reviewing the limited opportunities in Costa Rica for community involvement, we can infer that the main reasons for public involvement are (1) to create additional money, manpower, and materials from community contributions; and (2) to gain support for the development and use of health services. Costa Rica follows what Susan Rifkin has called "the health planning approach for public involvement."<sup>30</sup> This approach grew out of the awareness that health care resources are unequally distributed and deny most of the people their right to health. Hence an argument is made for restructuring the health care delivery system in LDCs to promote preventive, rural, health clinic centered services delivered by medical auxiliaries. Laymen can participate in a consultative capacity under the leadership of the physician. Moreover, since the approach recognizes diversity within the community, the involvement of community leaders rather than community members is considered essential. Structures such as the community health committees are established to formalize the relationship between the professional and the community, so as to assure that changes in the health delivery system no longer require

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<sup>30</sup>. Rifkin, "Role of the Public in the Planning, Management, and Evaluation of Health Activities and Programmes," p. 380.



direct orders from the physician but can be channeled through the community leaders.<sup>31</sup> This interaction is of utmost importance in Costa Rica because physicians are a powerful group that has frequently resorted to strikes to get their demands met.<sup>32</sup> One of the most salient features of the "health planning approach for public involvement" is the creation of the community health worker (CHW), usually a layman trained in first-aid, simple curative techniques, preventive activities, and health education. CHWs have been described as both service extenders and agents of change who will promote new ideas about health behavior in the community. Most important, they are seen as an attempt to institutionalize involvement in health care and open a channel of communication between the professional and the community. The result is a gain in community manpower, money, and materials. The Health Centers Committees and the Community Health Program in Costa Rica have had the same result. As in Cuba, this strategy gives the community a very limited role in health planning. Most of the time, norms and standards are set nationally and the community is involved in implementing the program goals. As stated earlier, this is one of the reasons the CHW in Costa Rica feels unmotivated, they feel their input in health programming is very limited because the planning is done in the Ministry of Health central

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31. Ibid.

32. Mesa-Lago, "Health Care in Costa Rica," p. 20.

headquarters. The community also has a very limited role in the management of the plans. This role is reserved for the CHWs and influential community leaders who act as two-way communicators between the professionals and community members. This is the case in Costa Rica with the Municipal Health Associations and the Development Associations.

Despite the flaws in community participation, however, the dramatic improvement in health indices show that the urban and rural poor in Costa Rica are better off than their counterparts in the rest of Latin America. The urban and rural community health programs are responsible for a large part of this improvement because they targeted the most often neglected sectors of Latin American society, namely, low-income groups living in urban slums and in rural areas.

### Innovations

Since 1985, the Ministry of Health and the CCSS have begun to integrate health services to improve quality, equity, and coverage leading to a National Health System to provide comprehensive care for the entire population. Among the goals of this new model relevant to PHC delivery are (1) to increase the coverage of PHC to low-income populations; and (2) to develop an integral treatment

program for refugees and displaced communities.<sup>33</sup> To increase coverage of PHC services, the Integral Health Center has been established as the basic unit of the health area. This center will provide health promotion, prevention, curative care, and rehabilitation. It will provide care to the family as a whole and environmental health services. The center will be staffed by professional and auxiliary personnel. It will be financed by both the CCSS and the Ministry of Health. The Ministry of Health will continue to pay for care to indigents.

In spite of the efforts to achieve integration of services, the continuous devaluation of Costa Rican currency and increases in costs have hampered the development of the National Health System.<sup>34</sup>

## Achievements and Constraints

### First-Contact Care

In Costa Rica, accessibility to PHC services is established by two routes. The individual seeks care either in the rural health post or health center or in the home when visited by a rural health assistant, auxiliary nurse, or

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<sup>33</sup>. Ministry of Health of Costa Rica et al., Priority Health Needs of Costa Rica (San Jose, C.R.: PASCAP/OPS/OMS, 1985), p. 23.

<sup>34</sup>. Antillon and Gutierrez, La Integracion de Servicios de Salud, p. 37.

community health assistant. Owing to the economic crisis existent in Costa Rica, however, coverage through the rural health program has been reduced to 57 percent and through the community health program to 49 percent.<sup>35</sup> Moreover, the emphasis given to curative and tertiary care has affected the regionalization process, the ability to extend coverage of PHC, and accessibility to the primary level.<sup>36</sup> The greater demands of the curative sector promote the construction of hospitals to the detriment of the primary level. In fact, the different regionalization schemes of the Ministry of Health and the CCSS hinder the coordination regionalization could promote. Moreover, the lack of coordination affects use patterns at the PHC level.<sup>37</sup> The result has been that patients skip the primary and secondary levels and go directly to the tertiary level.<sup>38</sup> Although the PHC units are supposedly open for eight working hours daily, sometimes they are closed because the personnel are involved in home-visiting activities. Thus the patients have no other option than to go directly to the secondary or tertiary levels.

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35. Saenz and Martinez, Aspectos Demograficos, p. 5.

36. Interview with Dr. Carlos Munoz.

37. Ibid.

38. Interview with Dr. Juan Jaramillo Antillon.

### Coordination of Care

In Costa Rica, continuity is maintained by having family medical records filled out by auxiliary personnel. These records contain information on the environmental and sanitation features of the dwelling in addition to the health profile of the family members. This information is used for future programming, however, not to assure coordination of care. Moreover, the family medical record is kept in the PHC unit and is not transferred when the patient is referred to higher levels of care.<sup>39</sup> Continuity is assured because the same auxiliary personnel provide follow-up care to the individuals in the home. Although the scheduled visits by physicians to the PHC unit hamper continuity. These physicians are recent graduates who are completing their compulsory year of service in the rural or urban marginal areas. Once the year is completed they leave and another physician takes charge.<sup>40</sup>

### Comprehensiveness

As stated earlier, to achieve comprehensiveness the PHC unit must be able to arrange for the patient to receive complete health care. In Costa Rica, this ideal is not

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<sup>39</sup>. Interview with Mary Morales.

<sup>40</sup>. Interview with Carlos Munoz.

achieved because the PHC unit can make referrals to the secondary or tertiary levels only for hospitalization or outpatient treatment.<sup>41</sup> It cannot arrange for other supporting services such as home care and other community services.<sup>41</sup> To achieve comprehensiveness, the PHC unit staff must know and be able to explain to the population served the health services for which the staff is responsible. In Costa Rica, the importance of community participation for the implementation and financial support of the programs compels the unit staff to explain to the community the services provided.

Finally, to achieve comprehensiveness preventive and curative activities must be provided, as well as the ability to recognize functional, organic, and social problems. In Costa Rica, although a curative approach is emphasized in the overall health system and levels of expenditures for curative care far exceed those of PHC, the health activities in the primary level are mostly preventive.<sup>42</sup> Curative activities can be arranged for, but they are not the main emphasis at that level. This also influences peoples' decisions to skip the primary level and go directly to the secondary level.

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41. Ibid.

42. Government of Costa Rica, Costa Rica.

## Longitudinality

A crucial element in achieving longitudinality is the extent to which the PHC facility can identify its eligible population and the population recognizes the PHC unit as a regular source of care. In Costa Rica, the number of inhabitants the rural post and the community health center must serve is well established.<sup>43</sup> Limited coverage and accessibility, encourage the population to skip the primary level and not to consider the PHC unit as their regular source of care.

## Conclusions

This chapter has shown that, unlike most LDCs, Costa Rica has made PHC services available to the urban and rural poor. The main emphasis of the PHC programs is on preventive actions. Yet the inability to coordinate the primary level with other levels of care has affected use patterns. The result has been that patients skip the primary level and go directly to the secondary or tertiary levels of care. Continuity of care is assured by medical records, but patient information is not transferred between levels of health care. This failing is a direct result of inadequate regionalization frameworks and deficiencies in the health planning process for

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<sup>43</sup>. Costa Rica, Ministry of Public Health, Rural Health Program.

regionalization. Continuity of care by the auxiliary health worker is very aggressive in providing follow-up care and seeking patients whether they are ill or not.

Costa Rica was able to improve health indices dramatically because morbidity and mortality were a result of communicable diseases. Therefore, new PHC models capable of preventing chronic diseases will have to be devised. The program Integrated Health Center is an effort in this direction.



## CHAPTER VI

### TWO KINDS OF HEALTH PLANNING

The health planning literature assumes that health actions in socialist countries are the result of the exclusive use of a formal systematic methodology for health planning. Moreover, it assumes that mixed economies have used only empirical or pragmatic health planning to design and implement their health actions.<sup>1</sup> Using Cuba and Costa Rica as case studies, this chapter will refute these claims. To provide such evidence, the health planning processes and their constraints in each country are examined. Finally, the chapter will present a comparative analysis of both countries' health planning processes.

#### CUBA

This section will discuss the way health planning is supposed to occur in Cuba and the actions taken in 1980 to draw up the 1981-85 Health Plan. Specific information on how health planning actually takes place is limited because of the difficulties in collecting data described in Chapter II. It was not until 1980 that a systematic methodology was used to elaborate the health plan.

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<sup>1</sup>. Wheeler, "Health Sector Planning," p. 206. See also Hilleboe, Barkhuus, and Thomas, "Approaches to National Health Planning."

Before 1980, the health sector relied on empirical or programmatic planning based on the experience and intuitive skill of the planner.

### The Institutional Framework

Although the health sector plan is elaborated within the framework of the economic development policy established by the Cuban Communist Party, the Ministry of Public Health (MINSAP) is the main institution involved in Cuban health planning. The central level of the MINSAP is responsible for determining health policy, developing general health standards, and elaborating and approving health plans. Refer to Figure 4.1.

The minister of health has two advisory organs: (1) the Management Council, consisting of the six vice-ministers of MINSAP, the vice-president of the Scientific Council, and other officials designated by the Ministers Council; and (2) the Scientific Council, which advises the minister of health on the scientific component of health actions.<sup>2</sup> Each of the six vice-ministers are each one entrusted with one sector. Such sectors are considered subsystems of the health sector. All activities related to medical care and environmental hygiene belong to the Health Services Subsystem. The

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2. Mario Escalona Reguera, Temas de Administracion de Servicios y Programas de Salud Publica (La Habana, Cuba: MINSAP - Instituto de Desarrollo de la Salud, 1983), p. 240.

Social Assistance Subsystem complements the former and provides services to the elderly and handicapped. It also helps establish relations with international organizations and foreign countries. The institutions involved in the training of health professionals form part of the Teaching Subsystem. The Research and Development Subsystem is particularly important for the health planning process because it proposes long-term health policy and directs research plans. All research institutes, the Health Statistics Office, and the Medical Sciences Information Center belong to this subsystem. The Economic Subsystem is charged with formulating investment plans. Finally, the Production Subsystem is responsible for the output and distribution of pharmaceuticals and medical and dental equipment.<sup>3</sup>

The provincial level of the Ministry of Health follows the standards established by the central level of MINSAP. From the administrative perspective, however, the provincial and municipal levels of MINSAP are directly accountable to People's Power at each level. In each of the fourteen provinces the Provincial Health Office is managed by a provincial director, who also presides over the People's Health Commission at the provincial level. The Management Council offers advice to the the provincial director on each of the four subsector specialty areas. These are (1) the Health Services subsector, responsible

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<sup>3</sup>. Ibid., pp. 241-243.

for medical care, dental care, and social assistance; (2) the Economic subsector, which controls accounting and economic plans, transportation, and the production and distribution of pharmaceuticals; (3) the Teaching subsector, which coordinates all health-related teaching activities at the provincial level; and (4) the Hygiene and Epidemiology subsector, which is charged with all sanitation and epidemiological activities in the province. In addition, three departments depend directly upon the provincial director: the Health Policy, Judicial, and Health Statistics departments.<sup>4</sup> Some provinces have additional responsibilities; for example, in the city of Havana province the economic subsector supervises eight enterprises responsible for the production and distribution of pharmaceuticals and medical equipment. In other provinces the teaching subsystem includes institutions that provide higher medical education and medical specializations.<sup>5</sup>

The health affairs of the municipality are managed by the Municipal Health Office. The organizational structure and management team vary according to (1) size of the municipality; (2) size of the population, (3) number of health-related units dependent on the municipality; and (4) functions they must undertake. Following these criteria

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<sup>4</sup>. Interview with Dr. Mario Escalona Reguera, director of teaching affairs, Institute for Health Development, La Habana, Cuba, October 26, 1983. See also, Reguera, Temas de Administracion, pp. 243-44.

<sup>5</sup>. Ibid.

the health sector classifies the 169 municipalities into A, B, and C in decreasing levels of complexity. For example, in the least complex--the type C municipality--the management team can be either the polyclinic health team or teams with varying levels of technical support. Municipalities classified as types A or B rely on management teams which fluctuate between 19 and 27 health workers.<sup>6</sup>

### Statistical Information System

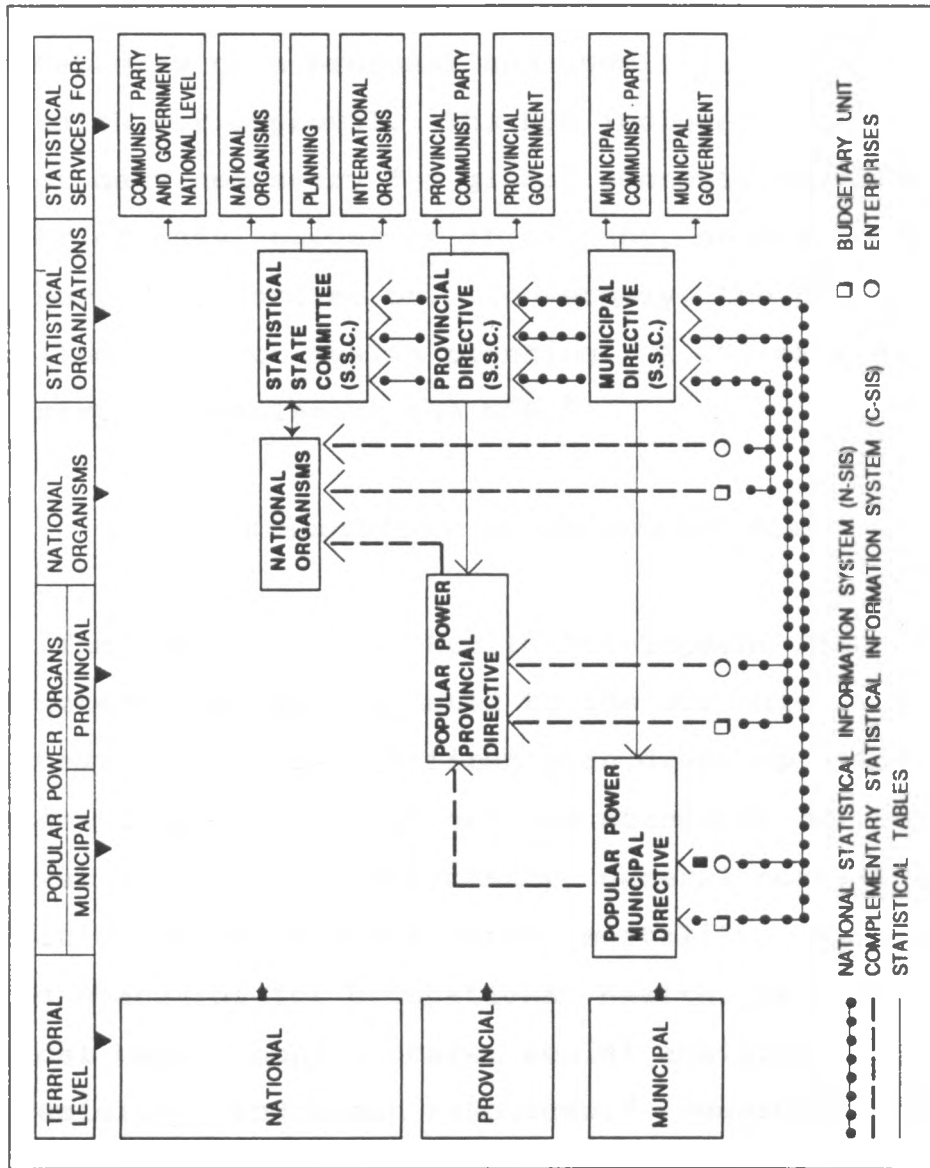
The Statistical State Committee (SSC) coordinates collection and analysis of health statistics with the Ministry of Health. In addition, it collects and processes statistics from all institutions involved in normative functions. Within the structure of the SSC, there are health statistics departments at the national, provincial, and municipal levels. At the latter two levels they are managed by the respective health director of People's Power.<sup>7</sup>

In Cuba, there are two statistical systems, the National Statistical System (NSS) and the Complementary Statistical System (CSS). The way each of these collects information is shown in Figure 7.1. The Department of

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<sup>6</sup>. Ibid.

<sup>7</sup>. Interview with Eneida Rios, director of the National Health Statistics Office, Ministry of Public Health, La Habana, July 14, 1983.



**Figure 6.1**  
**Health Statistics Information System in Cuba**

**Source:** Interview with Eneida Rios, director, National Health Statistics Office, MINSAP, La Habana, Cuba, July 14, 1983.

Health statistics at the national level in the SSC and the Health Statistics Office in MINSAP collect the statistics that make up the NSS. To coordinate health and economic planning, from the statistical point of view, the NSS and the CSS draw up a proposal and submit it to the minister of health for approval. The NSS includes general health sector data necessary for global economic planning such as number of beds, number of physicians, general mortality and morbidity, and so on. Conversely, the CSS includes detailed data for health planning. A CSS exists in each ministry to complement the NSS.<sup>8</sup>

#### Elaboration of the Health Plan

The 1981-85 Public Health Development Plan is a mediumterm plan subordinated to the economic development strategy. This was the first plan drawn up using systematic planning. It defined standards for health indexes such as life expectancy, general mortality, and reduction of child and maternal mortality. It also delineated standards for occupational health, ambulatory medical care, hospital care, social assistance, epidemiology, and human resources.<sup>9</sup> Regarding the

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<sup>8</sup>. Ibid.

<sup>9</sup>. Gutierrez and Reguera, "El Desarrollo de la Higiene Social," p. 309.

development of the standards for health planning in Cuba, Dr. Mario Escalona Reguera explains,

In 1977, a highly experienced health planner from the Soviet Ministry of Health provided consultancy services to the National Office of Health Policy of MINSAP. The advice he provided for a period of two years was extremely helpful and the result was the development of the System of Norms, Patterns, and Indexes for the Development of Health Until 1985. This document was immediately approved by the Minister of Health and quickly implemented. This was the first time health standards for health planning had been developed in MINSAP. In fact, since its approval this document has been the main tool for health planning.<sup>10</sup>

The health standards were based on studies undertaken to define the long-term public health strategy and the 1981-85 Five-Year Economic Development Plan. Regarding the development of health standards, Dr. R. Hernandez Elias, a health planner within MINSAP, asserts,

Health standards and indexes used in other socialist countries were analyzed extensively. However, the standards finally defined were adapted to the specific Cuban health situation.<sup>11</sup>

It was soon realized that the development of a public health plan required a parallel study on the current status of the health sector. Research was then performed to define the features of the health system, including its interdependencies with the economic and social characteris-

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<sup>10</sup>. Gutierrez and Reguera, El Proceso Investigativo, p. 18. Interview with Dr. R. Hernandez Elias.

<sup>11</sup>. Interview with Dr. R. Hernandez Elias.



tics of each of the fourteen provinces in Cuba.<sup>12</sup> This was a major interdisciplinary study undertaken jointly by the Institute for Health Development and the National Office of Health Policy of MINSAP. The research objectives were to (1) describe the social and economic characteristics of each province; (2) identify the present health situation; (3) describe the results achieved by the health sector until 1980 using the norms and indexes established before 1985; (4) define the results the health sector should attain (by 1985) in each province according to the standards established; and (5) identify the obstacles that might hinder achieving such standards.<sup>13</sup> The results of this study have not been made available. Dr. Mario Escalona Reguera explains that

the results of this research are not available to the public because our government considers the data to be "classified information" and a "State secret."<sup>14</sup>

In light of the eagerness of the Cuban government to show its health system and achievements to international

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12. Presently, in Cuba all health services research is done in coordination with the health services units, teaching institutions, and research institutions. Thus, all health research is oriented towards the solution of a health problem not merely for theoretical considerations. See, Gutierrez and Reguera, El Proceso Investigativo, p. 24.

13. Ibid., pp. 39-40.

14. Interview with Dr. Mario Escalona Reguera, See also Arsenio Carmona Gutierrez and Mario Escalona Reguera, "El Proceso Investigativo en la Planificacion de la Salud," Revista Cubana de Administracion de la Salud 8 no. 4, (October/December, 1982): 407.

health organizations and foreign visitors, it is surprising that the results of the most comprehensive health sector study ever done in Cuba have not been made public. The most plausible explanation is that the findings do not support widely accepted "achievements" in the health sector.

Before 1978 health planning in Cuba did not include economic and social considerations. Since 1978, the objectives of the health plan must correspond with the viability of the Cuban economy, and health planning is evaluated by the economic planners in the context of the development strategy and of the remaining sectors of the economy. Health planning emphasizes thus the intersectoral nature of health.

The health planning process is similar to the economic planning process, and similar steps are followed for its elaboration. The health sector plan is drawn within the framework of the economic development policy established by the Cuban Communist Party Politbureau (CCPP). After the CCPP directives are defined, the National Assembly of People's Power commissions the Ministers Council to prepare the plan proposal. The council delegates this responsibility to JUCEPLAN (Ministry of Economic Planning). Specifically, the National Health Sector Office within JUCEPLAN takes over this task and sends general guidelines for health planning to MINSAP at the national level. Following the guidelines from JUCEPLAN, and the input from the six subsystems (which constitute

the Management Council at the national level), the National Health Policy Office within the Research and Development Subsystem and the Planning Office within the Economic Subsystem elaborate the first version of the plan. The former is charged with planning human resources and health programs and the latter with planning material and technical resources. Regarding the interaction between JUCEPLAN and MINSAP, Dr. R. Hernandez Elias explains,

The Health Sector Office in JUCEPLAN is staffed by planners, while the Health Policy Office in MINSAP is staffed by physicians. The planners in JUCEPLAN consult the planners in MINSAP mostly when health or medical questions emerge. They also provide technical know-how to MINSAP.<sup>15</sup>

The first version of the plan is sent to the Provincial Health Office in each of the fourteen provinces and is discussed among the latter and the Provincial Assembly of People's Power. This version provides general guidelines for each province to draw up a provincial health plan. Although the provincial level keeps up-to-date information and statistics on the health situation of each of the municipalities forming the province, apparently the municipal level does not participate actively in the health planning process.

Afterward, the Health Policy Office and the Planning Office in MINSAP receive the plans from the fourteen provinces, incorporate their assessments, and send the plan to the Health Sector Office in JUCEPLAN after analyzing the plan by study areas, such as evaluation of the health

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<sup>15</sup>. Interview with Dr. R. Hernandez Elias.

situation, human resources, morbidity, and so on. JUCEPLAN compares the provincial and national plans with the health standards previously determined and completes the second version of the plan. This plan follows the same route as the first versions. Finally, JUCEPLAN formulates the third version, called Plan Project. This plan determines the goals the health sector must attain by the end of the plan period to meet the standards established. This last version of the plan is sent to the Ministers Council and to the Communist Party. Both make the suggestions and changes they consider necessary according to the financial viability of the Cuban economy and the areas they want to promote. The health plan is then submitted to the National Assembly of People's Power approval.<sup>16</sup>

This is the path the health planning process is supposed to follow; however, the elaboration of the 1981-85 Provincial Health Plan differed in some aspects. As stated earlier, the 1981-85 Health Plan was based on the interdisciplinary study undertaken in each of the provinces by the Health Policy Office of MINSAP and the Institute for Health Development. To undertake this task, fifteen physicians and/or dentists completing their residency in public health administration were assigned to perform the research in each province. After the research was completed, they elaborated the health plan for that

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16. Ibid.

province. This plan was discussed and approved by the health authorities of the provincial health sector.

Finally, the faculty of the Institute for Health Development, the health provincial directors, and the provincial planning directors analyzed the complete set of provincial plans and included recommendations.<sup>17</sup>

Therefore, although a framework for health planning exists in Cuba, health planning as a process has not been successfully established.

### The Health Budget

The public health budget includes funds to finance health institutions, investments, and salaries. The annual budget for health in 1982 was 594,691,500 Cuban pesos,<sup>18</sup> or 7.8 percent of the total national budget. Dr. R. Hernandez Elias asserts,

Our budget allocation strategy is to assign a set amount to health, but not to disaggregate the budget by areas. This is so, because we cannot plan ahead of time how much we will spend in each health area. For example, our involvement in providing international medical aid and in becoming a world medical power brings about unexpected expenses we cannot foresee. We act according to circumstances and do not limit our health actions because of budgetary constraints.

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<sup>17</sup>. Gutierrez and Reguera, "El Proceso Investigativo," pp. 424-36.

<sup>18</sup>. Ministerio de Salud Publica, Republica de Cuba, Informe a la Asamblea Nacional del Poder Popular (La Habana, Cuba: MINSAP, 1983), p. 48.

Moreover, if we run out of funds we know we can rely on State monetary reserves.<sup>19</sup>

JUCEPLAN is supposed to coordinate the public health budget with the national budget through indexes that standardize the financing of health institutions, investments, and salaries.<sup>20</sup>

### Constraints

To assess the limitations of Cuba's health planning process the following factors will be considered: (1) the institutional framework for planning; (2) the quality of health statistics; (3) the ability to use the health planning process to make projections for long-term planning; (4) the role of mass organizations in the planning process; (5) the dominance of physicians in the health sector; and (6) the health budget.

A clear delineation of the activities undertaken by each of the institutions forming the network that provides health services is an important step in planning public health. This is particularly important when the health system has been regionalized. Classifying the health institutional framework by categories, however, requires

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<sup>19</sup>. Interview with Dr. R. Hernandez Elias.

<sup>20</sup>. Jose Cobas Manrique and Sergio Ledo Duarte, "Lugar de la Salud Publica en el Sistema de Indicadores del Plan de la Economia Nacional," Revista Cubana de Administracion de la Salud, January/February 1982, pp. 51-54.

analyzing multiple elements. Examples of such elements are (1) demographic traits of the population served; (2) services to be offered and delineation of functions; (3) resources available; (4) equipment required; (5) inter-relationships among institutions; (6) long-term economic and social development of institutional location; and (7) accessibility to location. Moreover, the health system needs adequate information regarding the morbidity pattern of the population so it can make projections of future health needs and health institutions required. Cuban health planners have studied extensively the implementation of such elements in the USSR and in Bulgaria, but presently in Cuba these elements are not considered when planning the institutional framework. Dr. Sergio R. Ledo Duarte and Jose Cobas Manrique, two officials of the National Office of Health Policy of MINSAP, explain,

The designation given to the institutions involved in providing PHC, hospital care, and some in the tertiary level does not reflect the marked differences in structural and functional traits among them. For example, the definition of community or urban polyclinic resembles that of the rural hospital denoting similar functions and distinguishing the rural hospital only by bed availability. Also, two hospitals in the same administrative level, such as municipal or provincial, have a similar designation regardless of their functions. Moreover, some research institutes are being used to provide medical care.<sup>21</sup>

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<sup>21</sup>. Sergio R. Ledo Duarte and Jose Cobas Manrique, "Consideraciones sobre la Nomenclatura y Tipificacion de las Unidades del Sistema Nacional de Salud," Revista Cubana de la Administracion de la Salud, January-March, 1982, p. 56.

Therefore, the designation given to some of the health institutions in Cuba works against the optimal performance of the health planning process. Adequate information on the morbidity pattern of the population is also presently lacking in Cuba. Morbidity indexes are closely related to the volume of hospital care and ambulatory PHC. Both services require a large amount of health resources. In Cuba, the morbidity studies that do exist are not broken down by ages and provinces. Although they describe large segments of the population they do not distinguish morbidity patterns for specific segments of the population.<sup>22</sup>

The quality of health statistics is another important element of health planning. In the Cuban case, a generalized consensus exists that health statistics are reliable.<sup>23</sup> A study performed in 1974 by a Pan American Health Organization officer, Ruth R. Puffer, regarding the quality and coverage of health statistics in Cuba concluded that they were in accordance with PAHO standards. In fact, the recommendations she offered to improve some statistical reporting were already being

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<sup>22</sup>. Sergio R. Ledo Duarte and Jose Cobas Manrique, "La Morbilidad y el Proceso de Planificación de la Salud," Revista Cubana de la Administración de la Salud 7 (July/September 1981): 326-28.

<sup>23</sup>. There is only one study that reports that Cuban health and education statistics are unreliable, Nick Ederstadt, "Literacy and Health: The Cuban 'Model'," Wall Street Journal, December 10, 1984.



implemented.<sup>24</sup> Similarly, an evaluation of Cuban mortality data undertaken by Sergio Diaz-Briquets concludes:

In general, the data available since the late 1960s appears to be of exceptional quality, particularly for a developing country.<sup>25</sup>

We have seen that the collection of health statistics and their incorporation into the health planning process follow a logical sequence. The interaction between the framework for collection of health statistics and the framework for health planning are synchronized.

Vicente Navarro and Cuban health officials repeatedly extol the role of mass organizations in the health planning process and implementation.<sup>26</sup> We have seen, however, that community participation in health-related activities is limited to the implementation of health programs elaborated by the top health policy makers. This evidence supports David Werner's assessment of community participation in

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<sup>24</sup>. Ruth R. Puffer, Informe Acerca de la Calidad y Cobertura de las Estadísticas Vitales y Sobre Investigaciones de Mortalidad Perinatal e Infantil en Cuba (Washington, D.C.: OPS, 1974), pp. 8-9.

<sup>25</sup>. Diaz-Briquets, Health Revolution in Cuba, p. 144.

<sup>26</sup>. For example, Vicente Navarro argues that the Committees for the Defense of the Revolution, the Cuban Trade Union, the Federation of Small Farmers, and the Federation of Cuban Women are the main organizations involved in stimulating community participation in the decision-making process in Cuba. For more information see Vicente Navarro, "Workers and Community Participation and Democratic Control in Cuba," International Journal of Health Services 10, no.2 (1980): 197-215.

health sector decision making in Cuba, as exemplified in the following statement,

The "power of the people" to influence official decision-making--while it may function moderately well with regard to details in the implementation of established policy--functions poorly if at all with regard to policy-making per se. It appears that major policies are rarely debated upon by, or even in, the public. They are decided upon by top officials, and then announced.<sup>27</sup>

Moreover, Jorge Dominguez argues that since the late 1970s, political stratification has emerged in the Committees for the Defense of the Revolution and the Womens Federation. Since 1980, the share of the adult population in both organizations has not increased because of a rigorous selection process for new members following "political-ideological development" criteria. This mechanism helps maintain political coherence and limits mass participation and local democracy, not only in health but in all aspects that affect the local citizenship.<sup>28</sup> Indeed, the final approval of the health plan given by the National Assembly of People's Power seems more a formality than a debate on the policies involved.

Regardless of socioeconomic system, the life-and-death responsibilities of the physician are used to provide ideological justification for dominance in the

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27. David Werner, Health Care in Cuba Today: A Model Service or a Means of Social Control--Or Both (Palo Alto, Calif.: Hesperian Foundation, 1979), p. 28.

28. Jorge I. Dominguez, "Revolutionary Politics: The New Demands for Orderliness," in Jorge I. Dominguez, ed., Cuba: Internal and International Affairs (Beverly Hills: Sage 1982), p. 21.

doctor-patient context. This preeminence manifests itself in other areas such as health planning, health services organization, and resource allocation in the health sector. It enables physicians to use their authority in areas where the technical issues of curative medicine have a minor role.<sup>29</sup> Cuba is particularly noteworthy for the dominance of physicians in health planning. As stated earlier, whereas the Health Sector Office of JUCEPLAN is staffed by planners, the Health Policy Office in MINSAP is staffed mostly by physicians; both are the primary entities involved in health planning. It appears, however, that planners in JUCEPLAN are primarily involved in coordinating the health plan with the economic plan from the economic point of view. The priority given to particular health areas and the strategy used to implement such plans are decided upon by physicians in the Health Policy Office in MINSAP. The best example of such dominance is the elaboration of the 1981-85 provincial health plan. As may be recalled, it was drawn up by one medical or dental resident in each province. This situation is prevalent despite physicians' recognition that they have little or no administrative and planning

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29. Emanuel De Kadt, "Ideology, Social Policy, Health and Health Services: A Field of Complex Interactions," Social Science and Medicine (16):1982, p. 746. For more information on physicians' dominance of the health sector in Cuba and in Colombia, see Antonio Ugalde, "The Role of the Medical Profession in Public Health Policy Making--The Case of Colombia," Social Science and Medicine 13C (1979): 109.

expertise.<sup>30</sup> Hence they rely heavily on planners within JUCEPLAN for planning skills, although their training is in economic, not health planning. Probably the only difference between physicians dominance in Cuba and in other nonsocialist LDCs is the increased exposure of Cuban medical students to community medicine. Also, only the top 10 per cent of each medical class is eligible for public health residencies in an attempt to make the field of public health more attractive. Despite these measures, after two years of compulsory rural medical service, 80 percent of physicians still apply for residencies in the highly specialized, hospital-oriented, curative care.<sup>31</sup> By 1982, 45.6 percent of all physicians in Cuba were specialists.<sup>32</sup>

Among the contributing factors to physicians' dominance of the health sector in Cuba is that the physician is indisputably the mainstay of health manpower. By 1982, there were a total of 16,836 physicians and 20,217 medical students, that is, one physician for every 583 inhabitants. Cuba has chosen to use physicians not only to cover every aspect of curative medicine but also to administer community and preventive health activities. Their preeminent role is illustrated by their salaries. They are the highest paid workers in Cuban society, but

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<sup>30</sup>. Interview with Dr. R. Hernandez Elias.

<sup>31</sup>. David Werner, Health Care in Cuba Today, p. 14.

<sup>32</sup>. Ministerio de Salud Publica, Republica de Cuba, Informe a la Asamblea Nacional del Poder Popular, p. 38.

cannot earn extra income working overtime, a privilege the rest of Cuban workers have.<sup>33</sup> Thus Cuba is involved in a costly strategy of training an ever-increasing number of physicians. Cuban health officials try to justify their approach by insisting that a physician-dominated health delivery system guarantees the best possible care for the population.

The alleged absence of budget allocation by areas in the health sector contradicts the ability of JUCEPLAN to coordinate the economic plan with the health plan through budget plan indexes.

## COSTA RICA

This section will discuss the manner in which health planning is supposed to occur in Costa Rica and the actions taken during the 1982-86 government administration to draw the Health Plan. The multiple problems encountered in the health planning process are emphasized.

### The Institutional Framework

The main entity involved in health planning within the Ministry of Planning in Costa Rica (MIDEPLAN) is the Health Sectoral Planning Subsystem (HSPS) which is one of ten

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<sup>33</sup>. Interview with Dr. Elio Garrido Alvarez, National Polyclinics Office, Ministry of Public Health, La Habana, Cuba, July 20, 1983.

sectors forming the Sectoral Planning Subsystem (SPS) (see Figure 2.4). Regarding the nature of the SPS, Patricia Salgado, director of the Health Planning Sectoral Division within MIDEPLAN, asserts:

each of the ten sectors forming the SPS have been established primarily for political deliberation. That is, to debate the probable political consequences of alternative policies.<sup>34</sup>

The HSPS follows the general policy guidelines determined by the president of Costa Rica and the policies that emerge from the Government Council, the Economic and Social Council, the National Development Plan, and the minister of health. It consists of the minister of health, the minister of MIDEPLAN, the minister of the presidency, the Costa Rican Institute of Sewers and Water, the Costa Rican Social Insurance Fund (CCSS), and the occupational risks program of the National Insurance Institute, the Health Research Institute, and the Medical Sciences School of the University of Costa Rica.<sup>35</sup>

The minister of health directs and coordinates the health sector at the national and regional levels. Together with the president of Costa Rica, he defines health policy. He also monitors whether the directives of the Budgetary Authority and the budgets of the health sector institutions are within the framework of health

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<sup>34</sup>. Interview with Patricia Salgado, director of the Health Planning Sectorial Division, Ministry of Planning of Costa Rica (MIDEPLAN), San Jose, Costa Rica, August 17, 1983.

<sup>35</sup>. Ibid.

sectoral policy. Most important, to establish a multisectoral projection of health problems, the minister of health coordinates health sector activities with the ministers of the Social Commission formed by the Ministry of Health, Ministry of Education, and Ministry of Labor.<sup>36</sup>

The National Health Sectoral Council is an advisory entity consisting of the minister of health; the minister of MIDEPLAN, the ministry of the presidency, the president of the Costa Rican Institute of Water and Sewers, and the executive president of the Costa Rican Social Insurance Fund. It is directed by the minister of health. It is supposed to analyze the political, technical, and institutional problems of the sector to advise the minister of health regarding sectoral policy. Presently, however, this entity is inoperative. Patricia Salgado, director of the Health Planning Sectoral Division within MIDEPLAN, asserts,

One of our main problems in establishing a sectoral policy is that the National Health Sectoral Council never meets. Although it was restructured in 1983 and we asked the Costa Rican Medical Association and the University of Costa Rica to participate in an advisory capacity it has never had one meeting. At this point, the president of Costa Rica has inquired about the reasons why this entity is inoperative given its importance to establish health sectoral policy.<sup>37</sup>

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<sup>36</sup>. Costa Rica, President of Costa Rica, Minister of Health, and Minister of MIDEPLAN, Decreto de Creacion del Subsistema de Direccion y Planificacion Sectorial del Sector Salud (San Jose, C.R.: Casa Presidencial de Costa Rica, 1983), p. 3.

<sup>37</sup>. Interview with Patricia Salgado.

The Sectoral Planning Executive Secretary of the health sector is supposed to act as the most important entity within the Health Sectoral Planning Subsystem. Its main functions are (1) to monitor the implementation of policies determined by the minister of health; (2) to elaborate the Health Sector Plan in coordination with the planning units of the health sector institutions; (3) to undertake health sector research projects at the regional and national levels; and (4) to analyze and evaluate technical cooperation, investments, and foreign financing of the health sector. But, this entity does not exercise these functions. In the words of Patricia Salgado,

each health-sector institution forming the health sector must provide its own technicians to the executive secretary of planning of the health sector. Although this entity is supposed to be the most important planning instrument of the health sector it is also presently inoperative. The minister of health never schedules a meeting with its members.<sup>38</sup>

The Sectoral Technical Committee is formed by the directors of the planning units of the health sector institutions and is responsible for coordination of planning among such institutions. Finally, the Inter-sectoral Technical Committee, composed of the director of the Sectoral Planning Division of MIDEPLAN and the directors of the ten sectoral planning executive secretaries, is charged with the technical coordination of the ten sectors in the formulation, implementation, and evaluation of the National Development Plan.

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38. Ibid.



## Elaboration of the Health Plan

As stated earlier, the health sectoral development plan must be elaborated within the framework of the National Development Plan. Following the policy directives established by the president of Costa Rica and MIDEPLAN, the Health Sectoral Planning Subsystem determines the policies will guide institutional health planning. Completing the National Development Plan in a reasonable period of time has become increasingly difficult. In the words of Patricia Salgado,

After the National Development Plan is published, the first step taken by the Health Sectoral Planning Subsystem is to elaborate the guiding framework for the following year. However, right now this government administration is in its second year and the National Development Plan has not been published yet.<sup>39</sup>

After the National Development Plan is published, the Sectoral planning executive secretary elaborates the guiding framework for the health sector Annual Operative Plan. The Annual Operative Plan becomes the guide for institutional health planning. Therefore, in Costa Rica health planning is presently done on an annual basis. Nevertheless, there are many problems with the elaboration of the guiding framework. Patricia Salgado explains,

The elaboration of the guiding framework takes so long that usually by the time they are completed the health programs have already been designed and it becomes increasingly difficult to tell program directors that their programs will be reduced or modified. Also, many programs

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39. Ibid.

have been implemented and the budget allocated before the guiding framework has been completed.<sup>40</sup>

The director of the health sector in MIDEPLAN has access to many institutions involved in the planning process. Thus from the technical point of view he is a key individual and the main adviser to the minister of health. For plan elaboration, he meets with the directors of the planning units of the health sector institutions. Regarding the topics discussed at such meetings, Patricia Salgado comments,

The main discussion topics at the meetings are health sector policies, coordinations and relationships that should exist among sectors, programs that should be transferred to other sectors, and long-term projections.<sup>41</sup>

Subsequently, MIDEPLAN coordinates the elaboration of the plan among the health sector institutions, and the plan proposal is submitted to the minister of health for final approval. Afterward, the minister of health submits a copy of the health plan to the Social Commission (composed of the social area ministers), and multisectoral solutions to health problems are sought among the ministers.

Presently, budgetary allocations are done separately from the health planning process. As we can see from Patricia Salgado's comments,

The Budgetary Authority has absolutely no relationship to the elaboration of the guiding framework or to the Sectoral Council. To avoid problems what I do is let the Budgetary Authori-

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40. Ibid.

41. Ibid.

ty know before they allocate our budget what types of programs we are planning to design. At this point, budgetary allocations are not made by sector or by program. A set amount is given to the Ministry of Health, the Costa Rican Social Insurance Fund, etc., but is not allocated by health programs within each ministry.<sup>42</sup>

The most interesting feature of the health planning process in Costa Rica is that once the plan has been approved and published, its implementation is not guaranteed. As the director of the Health Sector in MIDEPLAN comments,

Having a plan does not guarantee that the actions specified in the plan will be taken. Once published we have to continue negotiating for their implementation.<sup>43</sup>

Presently, regional plans are not formulated. Instead, once the health sector institutions receive the National Health Plan, each health unit programs its own health activities. Afterward, each individual region sends the program it has drafted to the health sector in MIDEPLAN at the central level. Finally, MIDEPLAN analyzes the regions' programs according to technical and administrative standards and sends its analysis to the regions and health units for their implementation.<sup>44</sup>

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42. Ibid.

43. Ibid.

44. Interview with Rodrigo Meneses, planning unit director, Ministry of Health of Costa Rica, San Jose, Costa Rica, August 12, 1983.

## Constraints

The limitations to Costa Rica's health planning process will be analyzed in relation to the following elements: (1) ability to use the health planning process to make projections for long-term planning; (2) the health budget; (3) the quality of health statistics; (4) the role of community participation in the planning process; and (5) the dominance of physicians in the health sector.

After the National Development Plan has been published, the first step taken by health planners in the Sectoral Planning Subsystem is the elaboration of the guiding framework for the following year. We have seen that the elaboration of the National Development Plan usually takes longer than planned. For example, by 1983 neither the first section of the 1982-86 plan nor the second part of the plan, which includes the programs to be followed by sectors, had been completed. Thus the trend to complete the plan by the end of the government administration period is still prevalent. By and large, the result is the inability to use the health planning process to make projections for long-term or even medium-term planning. The only option under such circumstances is to react on an annual basis. The inability to do long-term planning is exacerbated by the noncompulsory nature of the plan. Moreover, the absence of morbidity studies, broken down by ages and regions, hampers the

ability to make projections of future health needs and institutions.

Difficulties in delineating the guiding framework for health planning are also prevalent. Most health programs are drawn up and budgetary allocations made before the guiding framework has been completed. Consequently, the mechanism by which budgetary allocations are made is totally independent from the health planning process.

The quality of health statistics is an important factor when considering the health planning process. In Costa Rica, social statistics, specifically health statistics are deficient in quality and coverage. In this regard, Jorge Barboza, an economic planner in MIDEPLAN, states:

The quality and coverage of economic and social statistics in Costa Rica is deficient ... Also, the human and material resources used to process such statistics are limited and their training inadequate. During periods of economic crisis the usually scarce resources assigned to statistical analysis and publication are seriously threatened by budgetary cuts.<sup>45</sup>

Despite the presence of community, private sector, and municipality representatives in the health sector at the regional level, participation is limited to the implementation of health programs elaborated by top policy makers. This situation is a clear reflection of central government control and limited finances.

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<sup>45</sup>. Jorge E. Barboza and Carlos Raabe, "Notas Sobre Estadísticas e Indicadores Sociales: Referencia al Caso de Costa Rica," in R. Ramalinga Iyer et al., Centroamérica: Indicadores Socioeconómicos para el Desarrollo (San Jose, C.R.: FLACSO, 1983), p. 221.

One of the main flaws of the health planning process in Costa Rica is the unfamiliarity of the technicians in charge of carrying out the planning process with the sectoral planning scheme. The director of the Health Planning Sectoral Division in MIDEPLAN explains,

The concept of sectorality is rejected by the institutions forming the health sector deeming it unnecessary. In fact, the planning department within the Ministry of Health rejects the health planning division within MIDEPLAN. This animosity makes the coordination necessary between both entities very difficult.<sup>46</sup>

It must be realized that the planning unit in the Ministry of Health was the main health planning entity in Costa Rica long before the health planning division in MIDEPLAN existed. Institutional jealousy is prevalent among the two. Moreover, planning officials perceive problems from the point of view of their own sector and are unwilling to search for multisectoral solutions. The most plausible explanation for such unwillingness is the dominance of physicians within the health sector. As it relates to health planning, their dominance is more prevalent in the Ministry of Health than in MIDEPLAN because health planners within MIDEPLAN are not physicians: they are trained in public health and public administration. This might be a factor influencing the lack of coordination in health planning between the Ministry of Health and MIDEPLAN.

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<sup>46</sup>. Interview with Patricia Salgado.

Lastly, owing to the curative emphasis of the Costa Rican Social Insurance Fund (CCSS) as compared to the preventive emphasis promoted by the Ministry of Health, there has been a traditional animosity between these two entities. This animosity has been minimized in the last government administration (1982-86) because of the personal friendship between the minister of health and the director of the CCSS. According to the director of the Health Sectoral Planning Division of MIDEPLAN,

Given the traditional animosity between the Ministry of Health and the CCSS, the Health Sectoral Planning Division in MIDEPLAN tries to be fair to both and keep an equidistant position between both institutions when conflicts emerge.<sup>47</sup>

By and large, the result has been the continuity of health planning by sectors.

### Comparative Analysis

Cuba started using health planning methodologies in the 1960s. Empirical or pragmatic planning, formulated independent of the system of plans for economic and social development, was the predominant methodology. Yet the Cubans recognized the multiple determinants of health status and that the scope of health policy interventions covered areas beyond the direct provision of health services. The result was the use of the most advanced form of pragmatic planning, namely, comprehensive sectoral

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<sup>47</sup>. Interview with Patricia Salgado.

planning. It was not until 1977, after standards for health planning were developed, that a systematic or formal methodology was implemented. Such methodology resembled that used in the USSR, which emphasized the technical aspects of plan elaboration. Moreover, design standards for curative and preventive care were established to create a balance between the subsectors of the health plan and the economic plan. Conversely, in Costa Rica initial attempts at health planning started in 1971 through the first National Health Plan for Costa Rica. This health plan provided the conceptual framework for the programs developed throughout the 1974-80 period. The comprehensive view of health problems by Costa Rican officials led to the implementation of multiple actions to reduce health problems; however, the influence exerted by the Pan American Health Organization promoted the use of empirical planning. Surprisingly, the first health planning attempts in both Costa Rica and Cuba used comprehensive sectoral planning, the most advanced form of empirical planning. This finding goes against the assumption frequently encountered in the health planning literature that health actions in socialist countries are the result of the use of a formal systematic methodology and that only mixed economies use empirical or pragmatic health planning. Thus the first steps leading to a full-fledged PHC approach in both countries were made using program planning, not a formal, systematic methodology. Equally, in both countries the main health



policies centered around extension of coverage. The purpose was to increase access of health services to populations who traditionally had lacked such services, mainly rural and urban populations. The main goal in both countries was the control of infectious diseases.

In both countries, health policy formulation is determined by the highest powers in government and in the health sector. In Costa Rica, the Sectoral Health Planning Subsystem follows the policy directives of the president of Costa Rica, who in turn has been advised by the minister of health, the Government Council, and the Economic and Social Council, whereas in Cuba, the Cuban Communist Party Politbureau determines health policy with the advice of the Ministry of Health. Yet, through time both governments have found the provision of health care, primarily PHC, to be a politically acceptable idea that helps legitimize the socio political system. Thus political commitment for the implementation of PHC has been present in both cases. The PHC literature points out repeatedly that political will is a determining factor for PHC and that it arises from the colossal needs of LDCs to improve health care. Thus it is seen as a practical option by the political leadership. Yet the UNICEF/WHO Joint Committee on Health Policy points out that

political commitment does not arise out of abstract morality--from a pious change of heart--but from a country's concrete political

situation, which has its own historical determinants.<sup>48</sup>

Both Costa Rica and Cuba have been historically committed to improvement of the health status of their populations.

In Costa Rica and in Cuba, the health plan must refer to all institutions involved in health. But though in Costa Rica private sector institutions are excluded, in Cuba the small health private sector, is included in the health plan. It appears that this helps maintain some form of control over the physicians still offering private health services and the citizens who sponsor them.

The minister of health in Costa Rica has far more power than the minister of health in Cuba. The Costa Rican minister of health defines and directs health policy, directs and coordinates the health sector at the national and regional levels, and monitors the Budgetary Authority directives. He also approves the final version of the plan. In Cuba, the ministry of health as a whole is in charge of determination of health policy, elaboration of the health plan, and hierarchization of the units directly dependent on the central level. Thus the actions of the minister of health are dependent on advisory entities. Moreover, unlike the situation in Costa Rica, the final approval of the health plan is given by the National Assembly of People's Power after it has been sanctioned by

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<sup>48</sup>. UNICEF/WHO Joint Committee on Health Policy, National Decision-Making for Primary Health Care, p. 17.

the Ministers Council and the Cuban Communist Party Politbureau.

Although in Costa Rica inputs from various sectors are sought before the health plan is implemented, once the health plan has been drafted, the minister of health seeks multisectoral solutions to health problems through dialogue with other ministers. In Cuba, multisectoral solutions to health problems are sought before the health plan is drawn up. As a result, Cuba is in a better position to incorporate elements from primary health care to the national economic plan.

An element that greatly enhances the ability to implement the health plan in Cuba is that it is compulsory by law. In Costa Rica, once the health plan is approved it has to be continuously negotiated, hampering its chances for implementation.

The strong centralizing tendencies in Costa Rica's health planning process are manifested by the lack of regional health plans. Instead, institutional plans in the regions are drawn up and sent to the central level. In Cuba, despite the strong centralized power in the Ministry of Health, a provincial plan sensitive to the needs of each individual province is drawn up. In turn, the provincial plan becomes the framework for institutional planning at the provincial level.

Despite the formal establishment of community participation in both countries, the alleged participation in health actions occurs at the implementation level. The

public is not involved in health policy making in either country.

The ability to complete the elaboration of the plan in a reasonable period of time is crucial to its implementation. Cuba completes the plan before the plan period begins, but Costa Rica extends plan preparation until the government administration is ready to end. This is probably a reflection of Costa Rica's partial commitment to planning and Cuba's total dependency on planning to direct all economic and social sectors. By and large, the result has been that in Costa Rica, the health plan is formulated on an annual basis, whereas in Cuba, it is done for a five-year period and broken down on an annual basis.

Finally, an important limitation to the effective elaboration of the health plan in both countries is the deficient level of health planning expertise. In Costa Rica, planning technicians are unfamiliar with the sectoral planning scheme. This reinforces the institutional planning perspective that still prevails. They also rely on advice from PAHO for technical knowledge, which, in turn, reinforces programmatic planning. In Cuba, health planners are familiar with the sectoral health planning scheme, but their level of technical expertise in health planning is inadequate and forces them to depend on Soviet and Soviet block advisers for such knowledge.

## CHAPTER VII

### IMPLICATIONS FOR HEALTH PLANNING

The discussion in chapters IV-VI on the delivery of primary health care and the health planning methods used in Cuba and Costa Rica indicates that PHC services have been successfully provided and similar health planning methods utilized in both countries under different socioeconomic systems. This is surprising for it refutes the one-sided idea often maintained in the health literature that PHC can be fully implemented only within a socialist socioeconomic system. Equally, it disclaims the belief that systematic or comprehensive health planning is the prerogative of socialist socioeconomic systems whereas planning by programs occurs only in market or mixed-economies. It was found that political will (resulting from various factors) exercised by those in power, and simultaneous actions on many economic and social fronts to improve health are the determining elements. This chapter will discuss the broad implications for health planning of the evidence that has emerged from the Cuban and Costa Rican examples.

### Implications for Health Planning

The health planning literature stresses two points of view on the requirements for PHC implementation. First, it can be implemented most effectively in the context of a national health system. Second, the most feasible and realistic approach to PHC in LDCs is through health services programming. A close examination of three essential features for PHC implementation--coordination of health and development planning, regionalization of health services, and community participation in Cuba and Costa Rica--has shown that whether in a socialist or capitalist economy the implementation of PHC is a difficult task. For example, both countries lack an effective framework for the coordination of health and economic planning. Moreover, both Cuba and Costa Rica have been unable to coordinate the primary level with other levels of care with a direct result on use patterns. In both settings, patients skip the primary level and go directly to the secondary or tertiary levels of care. Also, although continuity of care is assured by medical records in both countries, information on patients is not transferred between levels of care. Continuity of care by the physician in Cuba or the auxiliary health worker in Costa Rica is very aggressive and provides follow-up care to patients whether they are ill or not. Finally, community participation in PHC occurs at the level of implementation, not in health policy making. Therefore, in either socio-

economic structure multiple elements are present that promote or hinder PHC. Most important, the similarities found among such elements in both settings were striking. However, because this research draws on the observations of two countries generalizations about the relationship of socioeconomic structure to PHC cannot be made.

The health planning literature often adduces that the coordination between health and development planning is dependent on the use of a systematic health planning methodology. Moreover, it argues that such methodology is the exclusive prerogative of socialist societies or of countries with nationalized health care systems. The dramatic improvement in health status in both Cuba and Costa Rica and the PHC strategy implemented in both countries occurred before "Health for All by the Year 2000" was proclaimed by the WHO and before a systematic health planning methodology was established in either country. What did exist in both cases was (1) political will to implement PHC strategies, and (2) the awareness among those involved in health planning that health status is the result of multiple determinants. As stated earlier, political commitment to PHC is the result of a country's political situation, which has its own historical determinants. Therefore, initiatives to ensure political commitment most likely will emerge from within the country and cannot be forced by international organizations or other mechanisms. Ministries of health, however, can propose to their governments mechanisms that would include

the actions required in all relevant social and economic sectors, such as interministerial committees with the authority to support the process from policy formulation to implementation, including resource allocation. In Cuba and Costa Rica, however, this political forum was non-existent at the time the most dramatic improvements in health were attained. Moreover, despite the existence of such a forum, at the present time budgetary allocations are done independently of health planning in both countries. Thus, although formal coordination between economic and health planning is desirable it is not necessary to wait for its establishment to implement PHC with positive results. What does appear to be an important requirement for successful PHC implementation is the use of a health planning methodology such as comprehensive sectoral planning that considers economic and social factors in addition to health and managerial data. In Cuba and Costa Rica, simultaneous actions were taken on many fronts to improve health. For such purposes, the most advanced form of pragmatic health planning was used, namely comprehensive sectoral planning. Not only were epidemiological and operational data used, but also economic and social data. The use of this health planning methodology or its equivalent would promote similar results as those obtained in Cuba and Costa Rica. Moreover, the strategy used by both countries of implementing simultaneous actions on many fronts to improve health, confirms an important assumption inherent



to the concept of "Health for All by the Year 2000," specifically, that health improvements in LDCs can be brought about by social policy independent of general increases in incomes, through better health services, education, nutrition, water supply, and sanitation.

As stated earlier, because this research draws on the observations of two countries generalizations about the relationship of socioeconomic structure to PHC cannot be made. However, the evidence from Cuba and Costa Rica indicates that probably a specific socioeconomic structure is not necessary for the implementation of PHC and improvement of health. Since the analysis of social, economic, and political factors is very important in the health planning process, health planning methodologies should develop criteria to examine such factors. None of the health planning methodologies existent nowadays helps elucidate how socioeconomic factors affect the decision-making process.

Regionalization is also considered by the WHO to be a requirement for the implementation of PHC. Both Cuba and Costa Rica have been relatively successful in setting up a structure for regionalized health services in an effort to reduce urban/rural disparities. A comparison of health care delivery indices between regions in both countries revealed significant regional disparities. Thus accessibility to and equitable distribution of health care resources are not as effective as the countries contend they are. This is a result of the lack of planning for

and equitable distribution of health care resources are not as effective as the countries contend they are. This is a result of the lack of planning for regionalization in both countries. For example, in Cuba the regionalization network does not respond to planning or to the characteristics of the provinces, specifically to the number of inhabitants. In Costa Rica, regional plans are non-existent and the Ministry of Health and Ministry of Planning have different regionalization frameworks. The resulting incongruity leads to the formulation of multiple plans for dissimilar regions, making it almost impossible to coordinate plans. Moreover, both countries have encountered multiple problems in establishing regionalization as a process. For example, in Costa Rica strong central control and lack of decision making at the regional level have promoted operational and administrative problems. The inability of regionalization to function properly results in the lack of coordination between the primary and secondary levels of care observed in both countries. Also, continuity of care is affected because patient information is not transferred properly between levels.

For LDCs to promote the implementation of PHC they have to analyze first the existing network of health services, and, based on such analysis, set up a regional framework of integrated services. This framework must consist of various health service areas or districts each with a specific capacity ranging from primary services at

the periphery to highly specialized services at the base facility. Thus, to achieve three of the four descriptive criteria for PHC, namely continuity of care, coordination of care, and longitudinality a regionalized health care system is required. Most important, the health system must be restructured to provide the essential elements of PHC at the first point of contact between individuals and the health system. According to the WHO, these include

education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.<sup>1</sup>

It must also include components from the health sector and from other sectors whose interrelated actions contribute to health and encompass the entire population on a basis of equity and responsible participation. One of the most important lessons LDCs can learn from Cuba and Costa Rica is that they can reorient their national health systems toward "health for all" and PHC within the resource constraints of poor countries. This can be done through increased external assistance, transfers of resources from other uses, and greater efficiency in use of resources.

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<sup>1</sup>. World Health Organization, Alma-Ata 1978: Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata. USSR, 6-12 September 1978 (Geneva: WHO, 1978), p. 4.

Community participation in health policy making and in health planning is a feature seldom seen in the implementation of PHC in LDCs. The evidence from Cuba and Costa Rica shows that health-policy formulation in both countries is determined by the highest powers of government. Equally, the overly centralized power structure is reflected in that the community participates only in the implementation of policies and programs, not in health planning. Remember that in both Cuba and Costa Rica, political affiliation is one criterion used to allow individuals to become involved in community work. Under such circumstances health planning strategies that involve the community actively in the planning process are essential. For this purpose, a clear national policy with appropriate legislative and budgetary measures to assure community participation independent of political affiliation will be needed. Mechanisms must also be created to assure that people can express their views on the health system and to control PHC in the community in which they live. For the community to participate responsibly, the people must be well informed. Thus a strong health education component should be provided to assure that the community will have a certain degree of health literacy and not feel threatened by the expertise of health professionals. An awareness of what the sociopolitical structure will promote and what it will oppose will help the community to participate more effectively. Knowing in advance the

obstacles to be faced, the community can design strategies to circumvent the constraints and achieve its goals.

### Conclusions

This chapter discussed the broad implications for health planning of the evidence found in Cuba and Costa Rica. It has shown that a formal structure to integrate economic and health planning, although desirable, is not absolutely necessary to implement PHC in LDCs. Equally, although community participation in health planning, not just in implementation, is the ideal, it is not an absolute requirement to attain PHC. Conversely, multiple problems emerge to promote PHC if the health system has not been regionalized. The most important implication for health planning, however, is that simultaneous actions in many social and economic fronts, not only in the health sector, are required to implement PHC effectively.

## CHAPTER VIII

### SUMMARY AND CONCLUSIONS

The preceding chapters have explored the following: (1) whether Cuba and Costa Rica have delivered PHC to the extent they claim; (2) what role, if any, the integration of economic and health planning, regionalization of health services, and community participation have played in the delivery of PHC; and (3) whether the delivery of PHC is dependent on health planning and, if so, what type. The purpose has been to establish the relationship between health planning and the delivery of PHC. This dissertation has examined the dynamics of these factors in the two Latin American countries with the best health indices. Both have had relatively good achievements in the implementation of PHC, but their socioeconomic structures are different: Cuba is a socialist, centrally planned economy, and Costa Rica is a capitalist, market economy.

The central questions of this research have been examined from the point of view of the fulfillment of the descriptive criteria for PHC in Cuba and Costa Rica. Such assessment served as background for the subsequent analysis of the pattern of interaction between the delivery of PHC and the health planning process, regionalization of health services, and community participation. These features were examined from a historical and institutional perspective. The data used for analytical purposes and to support the

arguments throughout the study were gathered in a variety of ways. These include an extensive literature review of the topics discussed and interviews with health and economic planning officials in the Health and Planning Ministries of Cuba and Costa Rica, the PHC unit staffs in both countries, and PAHO officials in Washington, D.C. Data also came from personal observations of health care delivery in Cuba and Costa Rica. The research activities in both countries were undertaken for a period of six months in Cuba and twelve months in Costa Rica between 1983 and 1985.

The findings demonstrate that Cuba and Costa Rica have been able to achieve positive results from the implementation of PHC despite the lack of formal integration between health and economic planning.

The most surprising finding, however, has been that the dramatic improvements in health status and in the health care delivery system for PHC were achieved through the use of empirical health planning (programmatic planning), before formal, systematic health planning was implemented. Thus it has been shown that independent of a country's level of development and political and socioeconomic structure, health status and health services can be improved if political will and commitment are prevalent among those in power. An examination of the historical development of both countries' socioeconomic and health development indicated that political commitment to improvement of health status has been prevalent through

time in both settings. In effect, the tenet of the conventional Marxist literature that the integration between health and economic planning is a natural consequence of the planning process under socialism was found to be inaccurate. Moreover, the seldom mentioned constraints to health planning in small and underdeveloped socialist and mixed-economy countries were identified to be similar in both case studies.

The research study began with an examination of the contentions that PHC can be implemented only within the context of a national health system or through health service programs. These contentions were analyzed using what the World Health Organization has defined as three of the most important features required to implement PHC regardless of socioeconomic system, namely coordination of economic and health planning, regionalization of health services, and community participation in health.

A brief historical review of Cuba's and Costa Rica's socioeconomic systems showed that neither country had to start from scratch to obtain its health achievements. Before the Cuban Revolution, Cuba ranked among the top three or four countries in Latin America in socioeconomic development, whereas Costa Rica had experienced marginal but sustained government involvement in health and education since the nineteenth century. Thus Costa Rica was prepared for the economic expansion it would undergo after the 1948 Civil War. A brief historical review of the health systems in both countries demonstrates that the



evolution of health planning is a direct result of economic planning. Most important, it was found that the greatest health achievements in both countries were reached at a time when programmatic, not systematic, health planning was the methodology used. At the time, the main health policies centered around extension of coverage to increase access to health services to populations who traditionally had lacked such services and to control infectious diseases. Health programs were designed which included not only epidemiological and operational data but also social and economic data.

It was found that whether in a mixed economy or a socialist economy the implementation of PHC is a difficult task with the presence of different features that promote or hinder its achievement in divergent socioeconomic systems. For example, it is widely accepted that Cuba's PHC approach is based on preventive health actions. The evidence shows, however, that Cuba provides a wide array of curative services at the primary level and some preventive activities, whereas Costa Rica emphasizes preventive action. Although Cuba has higher coverage and comprehensiveness than Costa Rica, it appears that the effect on health status balances out given the latter's emphasis on disease prevention.

Regarding the ability to establish regionalization as a process, more similarities than differences were found in the two countries. For example, both have been unable to coordinate the primary level with other levels of care

affecting use patterns. Also, continuity of care by the physician in Cuba and the auxiliary health worker in Costa Rica is very aggressive. In both cases, community participation was found to consist of involvement in the implementation of programs, not in health policy making or health planning. Most important, both countries have been able to improve health status because mortality and morbidity were the result of infectious diseases. Their concern for improvement of health status and their capacity to be innovative in the health sector have motivated research on new forms of health care at the primary level such as Physicians for 120 Families in Cuba and the Integrated Health Center in Costa Rica. Both occurrences are a reflection of the political commitment to health improvement in both countries.

Despite the lack of formal integration between economic and health planning, the problems in establishing regionalization as a process and limited community participation in health planning found in this study, Cuba and Costa Rica have been able to improve health status through the implementation of strategies that fulfill, with limitations, the descriptive criteria for PHC, namely first-contact care, coordination of care, comprehensiveness, and longitudinality. An important influential factor in both countries was that simultaneous efforts were made on many economic and social fronts. But

most important these changes could not have been achieved if political commitment to do so had not been present.

### Conclusions

The central conclusion of this dissertation is that health improvement and the effective implementation of PHC can be achieved in different settings if those with political power are willing to provide human and material resources in multiple social and economic fronts. Thus, the trip to good health has multiple roads.

Many health and non-health related activities were responsible for the achievements in health status and PHC in Cuba and Costa Rica. In addition, two kinds of health planning for PHC were used in both countries to implement PHC through time. Most importantly, both societies have shown a willingness to continue innovating the PHC strategy to adapt it to the country's changing health profile. Equally, a commitment to improve the health planning process and regionalization of health services is prevalent in both countries. Because this research study draws on the experiences of two countries generalizations about the relationship of socioeconomic structure to PHC cannot be made. However, Cuba and Costa Rica have demonstrated that despite deep economic problems they have been willing to invest scarce resources in health and in those sectors relevant to the improvement of health.

## APPENDIX A

## THE QUESTIONNAIRES

## Delivery of Primary Health Care

Basic Questions

- Is the PHC unit the first level of the health system?
- Does the health system require continuity of care at the primary level?
- What types of programs and services are offered at the primary level?
- Can the PHC unit identify the population it is supposed to service?

Purpose

- Assess the fulfillment of the descriptive criteria for PHC in Cuba and Costa Rica.

A. FIRST-CONTACT CARE

1. Is the first level of care geographically accessible?; Is it available to the public for extended hours?

a. Physical Accessibility

- Proportion of the population by province, region, or municipality who have access to the facility where primary care is offered.
- How many days a week and for how many hours is the PHC unit open?
- If a patient is referred to ambulatory services, how far is the next level of care of the health care system?

- How frequently are maternal and child health services offered; are these provided in the community or at a reasonable distance from the community; what is the average distance in the urban and in the rural areas?
- 2. Does the population consider that accessibility to the first level of health care is adequate?
- 3. Has any research been done that relates accessibility to PHC with, higher levels of utilization?

B. COORDINATION OF CARE

- 1. Can the patient see the same physician or health worker each time they visit the PHC facility or when they are visited by a PHC worker?
- 2. Do medical records contain information related to the global treatment of the patient? Do they contain information related to the secondary and tertiary services required for the patients treatment?
- 3. Does the coordination of care available at the primary level increase or reduce the possibility of recognizing health problems?

In order to recognize health problems the population must have a level of health-related knowledge and promulgation of health information is required. The following questions are to evaluate effectiveness of information dissemination:

- What type of health information is broadcast through the mass media?
- What types of mass media devices are used?
- How many hours a week are used for health radio programs?

- What proportion of the population has a radio or a television?

- Are there other means to disseminate information about health to the population, such as political parties, feminine organizations, schools, farmers organizations, etc.?

### C. COMPREHENSIVENESS

#### 1. Maternal-Infant Care

a. Which types of policies have been implemented to promote the health of mothers and children?

b. Have you developed any legislative projects to support health care for the whole family?

c. Regarding evaluation and control of the level of health of the mother and child:

- Have you designed and implemented studies to identify the health problems of vulnerable groups, such as: studies on perinatal mortality and maternal health; fertility patterns and women health problems, etc.?

- What is the maternal mortality rate and the infant mortality rate?

d. In terms of maternal-infant care within the primary level:

- What percentage of pregnant women receive pre-natal care in accordance with national standards?

- What percentage of births are followed-up according to national standards?

- What percentage of infants are born underweight?

- Do you provide family planning services at the primary level? What percentage of the female population make use of these services?

- What types of policies exist in terms of population control?

- Do you promote breast-feeding? What measures are taken to promote breast-feeding?

## 2. Occupational Health

- a. Do policies exist to protect and promote occupational health?
  - What types of programs exist, if any, to protect the workers health in the industry, agriculture, and public sectors?
  - What is the tendency observed in the morbidity and mortality rates of job-related illnesses and accidents?
  - What percentage of workers are protected against occupational risks?
- b. Is occupational health integrated to industrial and agricultural development projects?
- c. Do standards exist to promote active participation of workers in their own health?

## 3. Geriatric Health

- a. Do policies and programs exist to take care of the social and health needs of the elderly?
- b. Is the development of community services promoted to satisfy the needs of the elderly, such as social centers and home care?
- c. Is PHC emphasized in the training of specialists in geriatrics?

## 4. Nutrition

- a. Is there up-to-date information available of the nutritional status and food availability for certain socio-economic groups?
- b. Is there an institutionalized mechanism for nutritional planning and surveillance?
- c. Regarding nutrition in the PHC level:
  - Is there a nutritional surveillance program for mothers and children?

- What types of health education activities promote good nutritional practices?

- Have you developed standards and simplified methods to evaluate infants growth, mother-infant nutrition, malnutrition, to improve feeding practices, and nutrition education?

d. What types of activities promote the prevention and control of specific nutritional deficiencies?

## 5. Dental Health

a. Have preventive dental health activities been developed?

b. Regarding the integration of dental health services to the primary level:

- Is there a national dental program that includes curative and dental health care?

- What percentage of the population under 15 years old, and of the general population covered for dental care?

- What is the rate of professional and auxiliary personnel per capita; and the geographic distribution of such personnel?

## 6. Mental Health

1. Are mental health services incorporated to the overall health system?

- Has mental health been incorporated to PHC?

- What percentage of the population is covered for mental health?

- What percentage of PHC service units include mental health?



## 7. INFECTIOUS DISEASES

### 1. Diseases Preventable Through Vaccination

- a. Have immunization programs been developed and integrated with PHC services?
- b. What percentage of the population is vaccinated annually, by age group and geographic area?

### 2. Control of Diarrhea

- a. Have programs been developed to assure the integration of all strategies to control diarrhea, i.e., oral rehydration, nutrition, health education, food hygiene, water and environmental health, with PHC?

### 3. Acute Respiratory Infections

- a. Have PHC services been strengthened to help diagnose and treat acute respiratory infections?

### 4. Sexually Transmitted Diseases

- a. Are the activities to control sexually transmitted diseases integrated to PHC?

### 5. Eradication of Parasitic Diseases

- a. Are integrated methods available for the diagnosis, treatment, and control of parasitic diseases in the primary level?

## 8. CARDIOVASCULAR DISEASES AND CANCER

1. What are the mortality and morbidity rates for each?
2. Is there data available about the magnitude and distribution of these two chronic diseases?
3. Are control programs available, and are they incorporated to the primary level?

D. LONGITUDINALITY

1. Are those individuals clearly identified as patients of the PHC facility, aware they should use such facility to receive health care, and do they use it regularly as their point of entry to the health system?

## ECONOMIC PLANNING AND HEALTH PLANNING PROCESS

## Basic Questions

- Does the private medical sector influence the planning and implementation process undertaken by the economic planning and health planning sector?
- How does the planning and implementation process undertaken by the economic planning and health planning sector influence the attainment of PHC?

## Purpose

- Describe the interaction between the socio-economic structure and the features of PHC through the elucidation of the planning process in the economic sector and in the health sector, in addition to the characteristics of the private medical sector.

## A. ECONOMIC PLANNING SECTOR

1. Which are the main objectives of the economic development policies elaborated by the Planning Ministry?
2. Which economic policies are being used to plan economic development?
3. Which economic policies have been planned for the long-term?; for the short term?
4. What types of difficulties have emerged during the implementation of such economic policies? Which have been relatively easy to implement?
5. Which economic sectors are being promoted more intensely?
6. Do the objectives of the economic development strategy depend on the growth of these economic sectors?

7. Is there cooperation between the different economic sectors to plan the economic development strategy?
8. Is the type of planning used to implement the economic development strategy normative or indicative?
9. Which methodology (if any), is used to plan the economic development strategy in the following areas?
  - Determination of the level of economic development reached.
  - Determination of problems that emerge in the economic development process.
  - Elaboration of hypothesis related to the possible objectives and development strategies to be used in the future.
10. How does the decision-making process for economic development take place at the central and local level?
11. Does the development strategy emphasize the urban or rural areas, or both?
12. Is there a regionalization scheme for economic planning?
13. Are the activities promoted in the industrial sector and agricultural sector labor-intensive or capital-intensive?
14. What strategy or methodology is used to assign resources to the different economic sectors?
15. What type of technology is promoted to implement the economic development strategy? Is this technology imported and adapted to local conditions; produced locally; or imported and used directly?

## B. HEALTH PLANNING SECTOR

1. Which are the main goals and objectives of the health policies elaborated by the Ministry of Health?
2. How does the regionalized structure of the health system determine levels of authority, assignment of tasks, and their interrelationship?
3. Is the planning sector integrated to the administrative structure in each level?
4. Does health planning take place at the national, regional, and local level? How does the planning process occur in each level?
5. Is there coordination of the planning process between the health sector and other sectors at the national and regional level?
6. Do health planners use a well-defined structure and methodology, or is planning based on experience and intuition?
7. What type of methodology is used to draw-up the health plan in the following areas:?
  - Evaluation of the present health situation and of the manner in which it is expected to develop in the future;
  - Determination of present and future medical care requirements of the population;
  - Determination of the number of physicians and other health personnel the country will require; and the number that will be admitted to medical schools, nursing schools, etc.;
  - Determination of health indices to be used in the health plan during the plan period?
8. Within the health planning process, is a strategy or program chosen according to feasibility or according to pre-established criteria?
9. How is the allocation of resources and the health budget determined?
10. Is the entity involved in resources allocation a central-level institution, or is it divided among different agencies or levels of government?

11. Is the National Health Information System used to justify resources allocation decisions at the national level?
12. Is the planning process backed by information compiled within the National Health System?
13. How do you make sure that the data compiled by the National Health System is reliable?
14. Are trial research projects undertaken to try-out the different strategies or programs before implementing them?
15. Does plan implementation follow executive orders, budgetary assignments, or does each institution implement it on a voluntary basis?
16. Is there interaction between program planning and evaluation as a continuous process, or is planning and evaluation two separate activities?
17. Are there mechanisms available for citizens participation in the health planning process?

C. PRIVATE MEDICAL SECTOR

1. Regarding medical education:
  - How many teaching hours deal with curative medicine; how many with preventive medicine?
  - What percentage of learning experiences occur in the hospital; how many occur at the PHC level?
  - Are community problems studied by medical students at the primary level?
2. Are health workers responsible to the State once they graduate?
3. What percentage of health professionals work in the private sector? What percentage finance their studies through the State?
4. What percentage of costs in the health area correspond to expenditures of the private medical sector?

5. What percentage of the health budget goes to imported pharmaceutical products; to imported medical equipment?
6. Can the private medical sector use government health facilities?
7. Is health insurance compulsory for some sectors of the population?

## APPENDIX B

## WHO GLOBAL INDICATORS FOR PHC EVALUATION

A short list of indicators will be used for global monitoring and evaluation of the Strategy. This implies the commitment of countries, individually as well as collectively in regional groupings, to use at least these indicators and provide the necessary information on them. It is stressed that these constitute a minimal list so that all countries may be in a position to use them. Many countries will wish to use additional indicators in keeping with their needs and capacities. To this end they may find useful the WHO publication entitled Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000. Since average global values of indicators have little meaning, monitoring and evaluation at the global level will rely on indicators expressed in terms of the number of countries, as follows:

The number of countries in which:

(1) Health for all has received endorsement as policy at the highest official level, e.g., in the form of a declaration of commitment by the head of state; allocation of adequate resources equitably distributed; a high degree of community involvement; and the establishment of a suitable organizational framework and managerial process for national health development.

(2) Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning, i.e., active and effective mechanisms exist for people to express demands and needs; representatives of political parties and organized groups such as trade unions, women's organizations, farmers' or other occupational groups are participating actively; and decision-making on health matters is adequately decentralized to the various administrative levels.

(3) At least 5 per cent of the gross national product is spent on health.

(4) A reasonable percentage of the national health expenditure is devoted to local health care, i.e., first-level contact, including community health care, health center care, dispensary care and the like, excluding hospitals. The percentage considered "reasonable" will be arrived at through country studies.



(5) Resources are equitably distributed, in that the per capita expenditure as well as the staff and facilities devoted to PHC are similar for various population groups or geographical areas, such as urban and rural areas.

(6) The number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries.

(7) The nutritional status of children is adequate, in that:

- at least 90 percent of newborn infants have a birth weight of at least 2500 g;
- at least 90 percent of children have a weight for age that corresponds to the reference values given in Annex to Development of Indicators for Monitoring Progress Towards Health for All by the Year 2,000, cited above.

(8) The infant mortality rate for all identifiable subgroups is below 50 per 1000 live-births.

(9) Life expectancy at birth is over 60 years.

(10) The adult literacy rate at birth exceeds 70 percent.

(11) The gross national product per head exceeds US \$500.

Source: World Health Organization, Global Strategy for Health for All by the Year 2000, op.cit., pp. 74-76.

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